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Critical Strategies to Ensure Readmission Appropriateness

Joseph Zebrowitz, MD
Executive Vice President
Executive Health Resources

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Featured Speaker:
Joseph Zebrowitz, MD
Executive Vice President

Dr. Zebrowitz currently serves as Executive Vice President for Executive Health Resources (EHR). At present, more than 1000 hospital and healthcare organizations across the country are using EHR's solutions. Dr. Zebrowitz was instrumental in the development of EHR's suite of clinical revenue cycle management solutions, endorsed by the AHA as "Best in Class," and is highly involved in EHR's strategic planning. Dr. Zebrowitz regularly conducts educational sessions at EHR's client hospitals and has completed hundreds of regulatory assessment audits for EHR's hospital clients. Dr. Zebrowitz also oversees EHR's education and regulatory assessment teams.

Prior to joining EHR, Dr. Zebrowitz was a Founder and Vice President of Strategic Alliances at eHealthContracts, now Concuity Inc. Before Concuity, Dr. Zebrowitz was a practicing obstetrician/gynecologist at Abington Memorial Hospital in Pennsylvania. Dr. Zebrowitz received his medical degree from Temple University School of Medicine and a bachelor's degree from the University of Pennsylvania. He also attended the Wharton School of Business at the University of Pennsylvania.

Objectives

- High level
  - Ensure appropriate coordinated care to avoid the potentially preventable “linked” readmission
- Tactics for today (if we want to make it to the high level strategic objective)
  - Understand what readmission means to your organization
  - Based upon that understanding, create a daily process that:

1. identifies whether a patient hospital stay is a readmission
2. ensures the compliant certification of a readmission as “related” or “unrelated” for purposes of compliance with the regulations and achieving revenue integrity
3. gathers the data necessary to meet the high level strategic goal over time.

How Do We Know They Are Serious

- Healthcare reform included very specific language on readmissions
- Section 3025: Hospital Readmissions Reduction Program
- Basically, this outlines how Medicare Payments will be affected to account for what is perceived as excess readmissions

Section 3025

in order to account for excess readmissions in the hospital, the Secretary shall reduce the payments that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

‘‘(A) the **base operating DRG payment** amount (as defined in paragraph (2)) for the discharge; and

‘‘(B) **the adjustment factor** (described in paragraph (3)(A)) for the hospital for the fiscal year.

Adjustment Factor

- For ALL DRGs, payment will be reduced by:
- Base DRG payment * adjustment factor
- Adjustment factor =
  1- (aggregate base DRG payments for **excess readmissions** for relevant DRGs/aggregate base *DRG payments for all discharges for all DRGs)*
- *"**excess readmissions**" determined by comparing actual risk-adjusted readmissions to "expected" risk-adjusted readmissions (as det. by the Secretary)*

Payment Penalties for Readmissions

- Base DRG payment amounts in hospitals with excess readmissions are reduced by a factor determined by the level of “excess, preventable readmissions”
- Effective FY 2013
- Initially applied to **AMI, heart failure and pneumonia**
- 30 day readmission window is implied, but not clearly mandated
- Plan to expand in 2015 to 4 additional conditions (COPD, CABG, PTCA, and “other vascular”)

What Exactly is a Readmission According to the Healthcare Reform Bill?

READMISSION.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an **applicable condition for which there is an endorsed measure** described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

And What is an Applicable Condition?

APPLICABLE CONDITION.—The term ‘applicable condition’ means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

“(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are **high volume or high expenditures** under this title (or other criteria specified by the Secretary); and

“(ii) measures of such readmissions—

“(I) have been endorsed by the entity with a contract under section 1890(a); and

“(II) **such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge**

So We are Back to Where We Started!

- We need to decide what readmissions stand on their own and what readmissions are related to a prior claim
- We will need to watch the methodologies to make sure that “unrelated” is not just for expected readmission but truly means could not have been expected or prevented.

So, Let's Start Over!

- CMS reports 18% of Medicare Patients are readmitted within 30 days of discharge
- CMS believes many of these are either avoidable or unnecessary
- Estimates that $12B can be saved by reducing avoidable readmissions
- CMS also believes hospitals are financially rewarded for readmissions, and by eliminating this financial incentive, readmissions will be reduced
- Similar approach as to short stay admissions

Background: Issue at Hand

- **Care Transitions:** CMS tasks QIOs to review readmissions and work to reduce readmission rates as part of the 9th scope of work
- **Project RED** (Re-Engineered Discharge): Boston University Medical Center, AHRQ, and the National Heart Lung and Blood Institute
- **BOOST** (Better Outcomes for Older Adults Through Safe Transitions): Society of Hospital Medicine and The John A. Hartford Foundation
- **STAAR** (STate Action on Avoidable Rehospitalizations): Institute for Healthcare Improvement and The Commonwealth Fund

The Medical Evidence of Medically Unnecessary Readmissions of Medicare Patients

- Stephen F. Jencks, MD., MPH et al., New England Journal of Medicine, April 2, 2009 360(14):1418–2:
- Key Findings:
  - Readmission Rates:
    - 19.6% readmitted within 30 days of discharge
    - 34% readmitted within 90 days
    - 56% readmitted within one year.
  - 50% of patients readmitted within 30 days had no bill for a physician visit during that time.
  - 70% of postsurgical patients were readmitted for a medical condition, such as pneumonia or a urinary tract infection.
  - Readmission rates varied greatly from state to state, with the highest five states seeing rates 45 percent higher than the lowest five.
  - The five most common medical conditions for which hospital readmissions occur are: heart failure, pneumonia, chronic obstructive pulmonary disease, psychoses, and gastrointestinal problems.
  - The five most common surgical procedures are: cardiac stent placement, major hip or knee surgery, vascular surgery, major bowel surgery, and other hip or femur surgery.
  - The reason for the hospitalization and the length of stay contributed more to readmission than did demographic factors such as age, race, or presence of disability.

What Does This Tell You?

- First, we know there are specific areas CMS will look at
- We know that there are about 10 areas at highest risk for related readmissions
- Recognizing this is a UR challenge, a Quality Challenge, a Case Management Challenge, and a Business office Challenge is a big first step
- Next, start thinking about self audit to get you arms around the issues.

What is a Readmission?

- The Social Security (Medicare) Act: US Code Title 42 § 1395ww
- The Code of Federal Regulations: C.F.R. § 476.71
- CMS Manual Guidance:
  - CMS Publication 100-04 (The Medicare Claims Processing Manual), Chapter 3, Section 40.2.5
  - CMS Publication 100-10 (The Medicare Quality Improvement Organization Manual), Chapter 4, Section 4240
- Other Applicable Guidance:
  - MedLearn Matters MM3389
  - The Hospital Payment Monitoring Program (HPMP) Compliance Workbook, 2006 edition, revised 2008, page 43

US Code Title 42 § 1395ww

- (2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of subchapter XI of this chapter, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has **taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals**, or other inappropriate medical or other practices with respect to such individuals, the Secretary may—
- (A) **deny payment** (in whole or in part) under part A of this subchapter with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or
- (B) require the hospital to take other **corrective action** necessary to prevent or correct the inappropriate practice.

CMS Publication 100-04 (The Medicare Claims Processing Manual), Chapter 3, Section 40.2.5

- The QIOs may review acute care hospital admissions occurring within **30 days of discharge from an acute care hospital if both hospitals** are in the QIO's jurisdiction and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.
- **NOTE:** The QIO's authority to review and to deny readmissions when appropriate is **not** limited to readmissions within 30 days. **The QIO has the authority to deny the second admission to the same or another acute PPS hospital,** no matter how many days elapsed since the patient's discharge.
- When a patient is discharged/transferred *from* an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the **same day** for symptoms related to, or for evaluation and management of, the prior stay's medical condition, **hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.**
- **But, there is no guidance on how to handle readmissions that do not occur on the same calendar day**

What is a Readmission?

- QIO Manual -- Deny readmissions under the following circumstances:
  - If the readmission was medically unnecessary;
  - If the readmission resulted from a premature discharge from the same hospital; or
  - If the readmission was a result of circumvention of PPS by the same hospital (See §4255).
- HPMP Compliance Workbook Definition
  - Due to premature discharge or incomplete care or inappropriate transfer:
- Factors to be considered according to the QIO Manual include:
  - patient stability at the time of discharge
  - the presence of a problem in the first admission that required subsequent care
  - the readmission was related to technical problems such as scheduling of tests or procedures (“unavailability of surgical suite, the surgeon becomes ill, etc.”)

What is a Readmission?

- PEPPER definition
  - 30-day Readmissions to Same Hospital or Elsewhere (30-Day Readmit)
    - count of index (first) admissions for which a readmission occurred within 30 days to the same hospital or to another short-term acute care PPS hospital for the same beneficiary (identified using the Health Insurance Claim number); patient status of the index admission is not equal to 02 (discharged/transferred to a short-term general hospital for inpatient care)

Related vs. Unrelated Readmission?

- "Related"
  - Readmission related to care delivered during previous admission
  - Represents a potentially avoidable readmission
  - Compliant Medicare billing means either a combined DRG payment or no
- "Unrelated"
  - Readmission not related to previous admission
  - Appropriate readmission despite the timeframe in which readmission has occurred
  - May be compliantly billed under Medicare as separate DRGs

Related vs. Unrelated Readmission?

- What differentiates Related vs. Unrelated?
  - Different DRGs
    - Was the readmission DRG due to incomplete, incorrect or substandard care of secondary diagnosis during the prior admission?
    - Ex: Asthma and Diabetes
  - Same DRG
    - Was the patient's diagnosis at baseline at the time of or prior to the readmission?
    - Ex: CHF and CHF

Diagnoses that Most Often Preclude a Linked Readmission

- Important to consider in order to appropriately stream line the readmission review process

- *Trauma*
- *Burns*
- *Left AMA*
- *Major Metastatic Malignancies*

- Inappropriate exclusion of diagnoses from the readmission evaluative process could limit data collection necessary to implement effective programs to prevent potentially avoidable readmissions

Readmission Challenge: Behavioral Health- Avoidable Readmission or Chronic Disease?

- Many behavioral health diagnoses represent chronic illness which often have a progressive downward debilitating course regardless of intervention
- The often inevitable disease course coupled with limited benefits/resources provided to beneficiaries often results in increased utilization of tertiary care secondary to acute episodes of illness with medical complications
- Linked readmission with potential to avoid in the future or inevitable chronic course of disease?
- How is this different from the cardiac cripple with multiple distinct episodes of CHF requiring readmission regardless of outpatient interventions?

Tactics

- First, it is important to look at denials from two perspectives
  - Same Day – clear guidance to combine claims
  - Different day - guidance varies regionally
    - QIO's clearly may deny, but when we have seen denials, the recommended remedy is to combine episodes into a single claim
    - But some MAC's do not seem to be able to process this type of claim, and recommend complete denial of second claim, even if care was medically necessary
- As a hospital, you want to focus on areas you can improve

Tactics

- Consider audit of 30-40 readmissions – use NEJM and CMS targets as guidance
- We recommend looking at 14 day readmits and less first
- Identify sources of issues(are stays related or not, are there documentation issues, quality concerns, process issues, etc
- If discharge documentation is concern, consider discharge planning prompts to ensure co-morbid conditions are addressed in common problem areas
- Consider concurrent/retro review process
  - Review all readmissions for 1. Med Necessity and 2. Relatedness
    - Can be done by CM and Physician Advisor
    - Can be done at point of admission, or put in place notification process in business office

Tactics

- If claims are related you have some deciding
  - Combine Claims
  - Self-deny second claim
  - Submit separate bills with a note to MAC
- Due to regional differences, we recommend conferring with your MAC and getting written guidance on the process they consider compliant
- Continue to watch for more guidance from CMS.

Take Those Tactics and Consider the Implications of the Readmission Reduction Act

- We know that there will be a difference of opinion between hospitals and regulators about how many excess readmissions there are at a facility, since that is the basis for payment reduction
- If you have reviewed all readmissions and combined bills of all related readmissions(if allowed by the MAC), the only readmissions left will be unrelated
- If the only readmissions separately billed are unrelated, and unrelated readmissions must be excluded from the count of excess readmissions, your "excess readmissions" would be zero, and no reduction should be applied
- This strategy is contingent on:
  - A good process that actually looks closely at cases
  - The absence of further guidance from CMS or the Federal Gov't that makes the underlying assumptions invalid.
- No matter what, you want to be 100% compliant and not submit claims for reimbursement you are not entitled to

Readmission Example 1

- 65M admitted with glioblastoma, thalamic stroke. Started on decadron, obtained brain biopsy with high grade cancer. Decided on non-operative treatment. Consult with endocrinology, opted for oral diabetic medications due to prognosis. Glucose up to 405 prior to discharge, no further input from endocrinology. Discharge summary states on some sort of diabetes medication without instructions for self monitoring or close follow.
- Readmitted 4 days later with severe hyperglycemia (600) and altered mental status. Signs of wound infection, treated with dual antibiotics.
- Linked admission
  - First admission and second both medically necessary
  - Lack of plan for outpatient diabetic management makes this a readmission for a different reason, but still preventable
  - If a good plan was documented, it might have been argued that the elevated glucose was due to the wound infection, and could not have been prevented, but the lack of a plan makes this almost impossible.

Readmission Example 2

- 76M, elective femoral bypass due to rest pain and nonhealing ulcer with foul odor. PMH COPD, ESRD, DM, CAD. Received 2 doses of Ancef, no other antibiotics. Postoperative flow study borderline flow suspect outflow obstruction. (Minimal outpatient note serves as H&P, no discussion of ischemic vs infection component of ulcer or possible deep tissue infection).
- Readmitted 2 days later with foul odor and discharge from ulcer. Suspected osteomyelitis, failed bypass. Despite antibiotics, required amputation.
- Upon review, there were signs of osteomyelitis on exam in admission one that were not addressed.
- Again, this is hard to argue that the failure to address the osteomyelitis was not a contributing factor to the second admission.
- With appropriate documentation, could have been argued that there was no way to predict the failure of bypass, but since the problem existed on admission 1 and was not addressed, this would be incomplete care in the eyes of an auditor

Readmission Example 3

- 79F with PMH COPD, CAD, a fib on Coumadin. Underwent femoral bypass without complication. Hemoglobin dropped to 9.1 then 8.0. Transfused 2 units with serial Hgb 9.3, 8.6, 8.6.
- Readmitted 2 days later after vomiting blood. Hgb 7.7 BP 90 systolic BUN 46 Cr 2.2. EGD shows hemorrhagic gastritis.
- So, what was the problem here?

Premature Discharge

- 82F with prior abdominal surgery and adhesions, CHF, CAD. Presents with partial small bowel obstruction. IVF x 2 days, resume liquid diet on day 2, low residue diet on day 3 and discharge late day 3. Nursing notes state tolerating only small amounts of solids, concerned about fluid intake as well. No abdominal exam documented on day of discharge.
- Readmitted 1 day later with vomiting and distention. Radiographs show continued air fluid levels.

Sometimes the Documentation Does You In

- 85M with progressive dyspnea. CHF with EF 15-20%. BUN 28 Cr 1.75. Workup showed multivessel disease, cardiomyopathy of unclear etiology. Underwent 3 vessel CABG. Treated with ACEI and beta blockers. Diuretics used during post op period but not continued after transfer from ICU. No mention of long term diuretic use or reasons why not.
- Readmitted 3 days later with worsening dyspnea. Cardiologist note on readmission noted that patient did not receive diuretics (exact words are “diuretics are noticeably absent”) and appears volume overloaded. Responded to Lasix.

Summary

- Readmissions are a moving target
- Now is the time to get a handle on the issues that exist at your facility
- Step 1 is auditing
- Step 2 is assessing the root causes
- Step 3 is working with your compliance staff and MAC to implement a compliant process.

Useful Compliance Publications

Access the EHR Compliance Library,

log onto www.ehrdocs.com

select Resource Center, Compliance Library

- EHR Client Bulletins and archived audio conferences
- Latest CMS Recovery Audit Contractor (RAC) Demonstration Evaluation Reports
- Recent Report on Medicare Compliance articles
- RAC Program Legislation
- Revised Statements of Work for RAC Program

QUESTIONS?

Joseph Zebrowitz, MD
drjoe@ehrdocs.com
www.ehrdocs.com

About Executive Health Resources

EHR® received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of Medicare and Medicaid Compliance Services, including Medical Necessity Certification, Continued Stay Review and Denial Review and Appeal.

The American Hospital Association has exclusively endorsed Executive Health Resources' Medicare Compliance Management, Length of Stay Management, Retrospective Clinical Denials and Concurrent Clinical Denials Programs.

EHR has been recognized as one of the "Best Places to Work" in the Philadelphia region by Philadelphia Business Journal three years in a row.

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