Defending Your Hospital from the "RAC Attack"

Using Guidelines to Establish and Document Medical Necessity for Short Stay Admissions.

Prepared for the
Greater New York Hospital Association

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Milliman

Agenda

- Who is Milliman Inc.?
- CMS Recovery Audits
  - 2007 results
  - At risk
- Using evidence based guidelines to establish and document medical necessity
  - Successful programs
  - Milliman Care Guidelines

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CMS Recovery Audits[1]

- Use automated claims analysis systems to identify claims for medical records review
- Medical records review uses RNs and physician “Medical Directors” and “Accepted clinical standards of practice” to make decision regarding medical necessity for acute inpatient hospital admission
- 2007 recovery from NYS facilities for inpatient services = $ 99 million (97% from hospitals & 3% from SNFs)
- 2007 recovery from NYC physicians = $ 1.6 million
- Overturn rate on appeal = 5%

[1]CMS RAC Status Document FY 2007, US Dept of Health & Human Services

Selected "ST PEPPER" Target Conditions[2]

- Respiratory infections
- COPD
- 1 day stays for CHF/Chest Pain/Esophagitis/Gastritis/Nutritional & Metabolic Disorders
- Medical back problems
- **We believe all these to be associated with "medically unnecessary" admissions**

[2]Short-term Acute Care Program for Evaluating Payment Patterns Electronic Report

2007 CMS Recovery Audits Impact on NY Hospitals[1]

- 60% of hospitals - no impact
- 32% of hospitals - up to 2.5% of Medicare revenue
- 5% of hospital - up to 5% of Medicare revenue
- 1.4% of hospitals - up to 10% of Medicare revenue
- 1.4 % of hospitals – greater than 10% of Medicare revenue

[1]CMS RAC Status Document FY 2007, US Dept of Health & Human Services

Potential Impact on NYC Hospitals Based on Milliman Analysis[3]

- NYC metro hospital average % of total Medicare admissions with questionable medical necessity = 13%

[3] 2006 Milliman Hospital Efficiency Index - non-rehab, non-psych facilities

Potential % of Medicare Medicine Admissions At Risk for NYC Metro Facilities[3]

Facility	%
Hospital 1	**6%**
Hospitals 2, 3, 4, & 5	**7%**
Hospitals 6 & 7	**8%**
Hospitals 8, 9, & 10	**9%**
Hospitals 11, 12, & 13	**10%**
Hospitals 14 through 22	**11%**
Hospitals 23, 24, & 25	**12%**
Hospitals 26, 27, & 28	**15%**
Hospital 29	**16%**
Hospital 30	**17%**
Hospital 31	**18%**

[3] 2006 Milliman Hospital Efficiency Index - non-rehab, non-psych facilities with >3,000 Medicare discharges in 2006

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Milliman's NYC Experience Using Evidence Based Guidelines to Reduce Payment Denials

- Milliman has been working with selected NYC facilities to reduce payment denials for over 10 years
- All our hospital clients have better than average performance for avoidable admissions[3]
- Some have reduced payment denials from HMOs by >80%
- What have we learned?

[3] 2006 Milliman Hospital Efficiency Index - non-rehab, non-psych facilities with >2,900Medicare discharges in 2006

Characteristics of Programs Successful in Reducing Payment Denials

- Are driven by senior management (CEO, CFO, CMO, CNO, Department Chairs)
- Process is designed and implemented with input by front line leadership in case management, ED and clinical units
- Results are measured and reported on regular basis
- Results are often given a financial value
- Evidence based clinical guidelines are used as benchmarks to identify documentation gaps and avoidable admissions
- Development of documentation template for establishing admission medical necessity
- Training is key component

Evidenced Based Guidelines - Example

- *Milliman Care Guidelines examples of* ***Clinical Indications for Admission to Inpatient Care***
- ***Pneumonia, Community Acquired*** **Pneumonia M 282** *Admission may be indicated for* ***ANY ONE*** *of the following:*
  - *Hypoxia indicated by* ***ANY ONE*** *of the following:*
    - *Oxygen saturation less than 90% or PO2 less than 60 mm Hg while breathing room air*
    - *Chronic lung disease with significant deterioration from baseline oxygenation*
  - *Failure of, or inability to receive, outpatient or recovery facility diagnosis and therapy*
  - *Prior hospitalization within past 7 days*
  - *Unstable co-morbid condition*
  - *Complicated pleural effusions*
  - *Hemodynamic instability or suspected sepsis*
  - *Moderate- or high-risk category patients (Class IV or V).*
  - *Intermediate-risk category patients (Class III) who do not improve with initial therapy and observation.*
  - *Immunocompromised patients at moderate or high risk based on clinical evaluation*

Evidenced Based Guidelines – Example

- **Chest Pain M-89** **Admission is indicated for chest pain with ANY ONE of the following**:
- Evaluation of intermediate risk patients when **ALL** of the following are present:
  - No observation unit, chest pain unit, or other facilities available for evaluation of patient
  - Patient has intermediate risk (for acute coronary syndrome) stratification as indicated by **ANY ONE** of the following:
    - Abnormal ST segments or T waves not documented to be new
    - Fixed Q waves
    - Extracardiac vascular disease
    - Diabetes
    - Chest or left arm pain or discomfort as chief symptom
    - Age older than 70 years
- High risk (for acute coronary syndrome) stratification.
- Chest pain indicative of serious diagnosis other than coronary artery disease; examples include:
  - Aortic dissection - Mediastinitis
  - Pericardial disease with tamponade or impending tamponade
  - Pulmonary embolism.
  - Pneumothorax. - Pneumonia
- ST-segment elevation myocardial infarction.

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Evidenced Based Guidelines – Example

- **Back Pain M-63** Admission may be indicated for **ANY ONE** of the following:
- Cauda equina syndrome
- Progressive or severe neurologic deficit
- Spine fracture with significant damage to the vertebral column or spinal cord
- Severe pain or functional deficit that cannot be managed on an outpatient basis
- Other indications for intervention or surgery, including **ANY ONE** of the following:
  - Mass or other lesion with rapidly progressive neurologic deficits
  - Biopsy of neoplasm or other lesion
  - Epidural abscess
  - Aortic dissection or aneurysm
  - Suspicion of osteomyelitis

Evidenced Based Guidelines – Example

- **Syncope M-340** Admission may be indicated for syncope accompanied by **ANY ONE** of the following:
  - Systolic BP at the time of triage less than 90 mm Hg
  - Complaint of shortness of breath
  - History of congestive heart failure
  - Abnormal ECG as indicated by **ANY ONE** of the following:
    - New changes on ECG
    - Cardiac rhythm other than normal sinus
  - Hematocrit less than 30%
  - History of valvular aortic stenosis or hypertrophic cardiomyopathy
  - Suspicion of malignant arrhythmias as indicated by **ANY ONE** of the following:
    - History of malignant arrhythmias
    - Use of medication known to cause malignant arrhythmias
  - Symptoms or signs suggesting transient ischemic attack (TIA), stroke, or focal neurologic disorder. See related guidelines as appropriate.
  - Suspicion of other imminently dangerous causes (eg, rare causes such as pericardial tamponade, pulmonary embolism).

Evidenced Based Guidelines – Example

- **Gastroenteritis M170** and **Dehydration M-123 Admission may be indicated for ANY ONE of the following:**
- Postural hypotension unable to be corrected in outpatient setting
- Hemodynamic instability or shock
- Vomiting refractory to outpatient treatment (ie, precluding oral rehydration)
- Electrolyte imbalance unable to be corrected in outpatient setting
- Failure to remain hydrated with outpatient therapy
- **Additional indications for Gastroenteritis**:
- Suspected severe infection (eg, presence of high fever or bloody diarrhea
- Severe abdominal tenderness
- **Additional indications for Dehydrations**:
- Postural hypotension unable to be corrected in outpatient setting
- Serious cause for dehydration requiring acute hospitalization (eg, bowel obstruction, increased intracranial pressure, infectious cause)

Discussion & Questions