



HCCA's 12TH ANNUAL COMPLIANCE INSTITUTE

APRIL 13–16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

In Pursuit of Quality: Let The Data Be The Driver

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Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)

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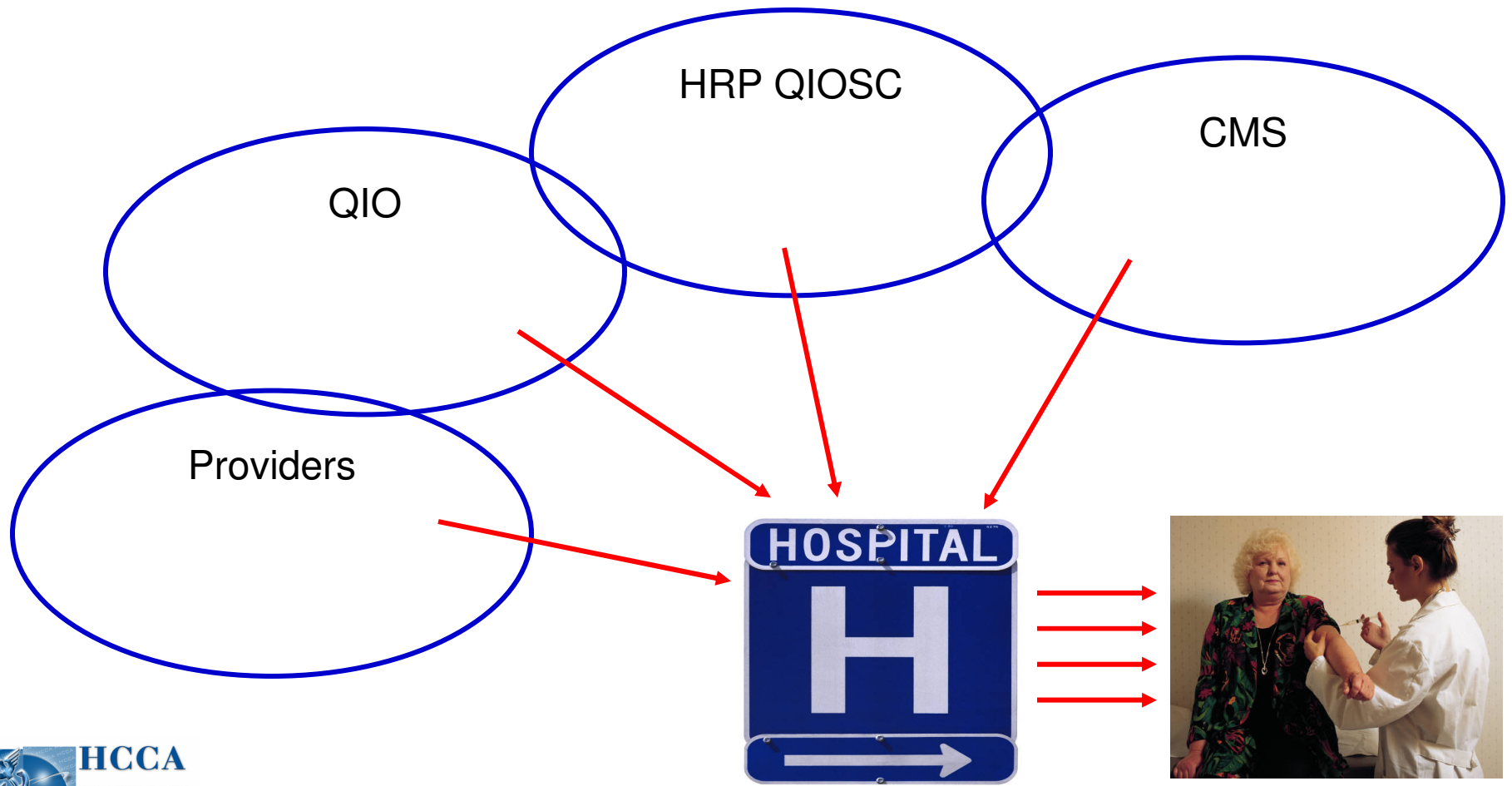


Objectives

- Understand the data abstraction, submission and validation processes
- Understand the significance of Hospital Compare and RHQDAPU
- Understand the connection between the reported quality measures and hospital goals of providing the right care for every patient, every time

Design Goal

Together, Our Goal is to Improve Quality of Care



Data Abstraction Process

- The Specifications Manual is the foundation upon which care is to be provided and other programs are built



Specifications Manual Versions

Data Collection Time Period	Specifications Manual
10/01/07 - 03/31/08	Version 2.3a
04/01/07 - 09/30/07	Version 2.2b
10/01/06 - 03/31/07	Version 2.1d
07/01/06 - 09/30/06	Version 2.0
04/01/06 - 06/30/06	Version 1.05
01/01/06 - 03/31/06	Version 1.04a
10/01/05 - 12/31/05	Version 1.03
07/01/05 - 09/30/05	Version 1.02
01/01/05 - 06/30/05	Version 1.01 Version 1.0



Uses for Data Collected

- Data submission to the QIO Clinical Warehouse
- Validation by clinical data abstraction contractor
- Reporting Hospital Quality Measures for Annual Payment Update - RHQDAPU
- Public reporting on Hospital Compare



Abstraction Barriers

- Staff turnover for abstractors
- Changes are posted before you have abstracted the current period
- Training case managers and other hospital personnel based on abstraction findings

Abstraction Barriers

- Changes to the practice guidelines requires updates to the measures
 - Recommendations by Technical Expert Panels
- Validation, abstraction and future changes to the manual are all occurring simultaneously for different periods of time
- Dependent on QIO or vendor to provide education
- Proof of care dependent on the documentation

Submission Process

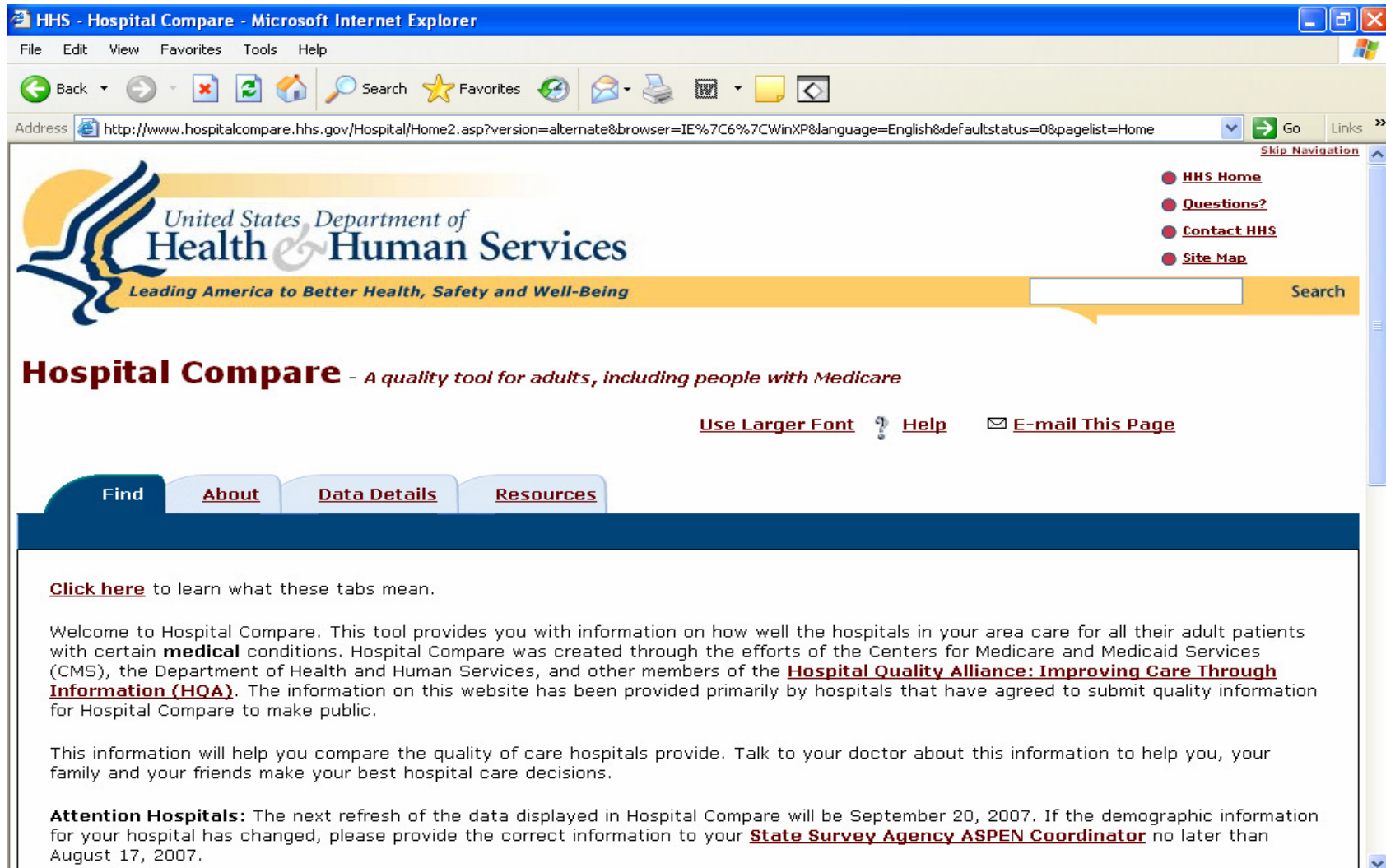
- Submission/Reporting Schedule

Discharge Quarter		Data Submission Deadline
3rd Quarter 2005	Jul-Sep	15-Feb-06
4th Quarter 2005	Oct-Dec	15-May-06
1st Quarter 2006	Jan-Mar	15-Aug-06
2nd Quarter 2006	Apr-Jun	15-Nov-06
3rd Quarter 2006	Jul-Sep	15-Feb-07
4th Quarter 2006	Oct-Dec	15-May-07
1st Quarter 2007	Jan-Mar	15-Aug-07
2nd Quarter 2007	Apr-Jun	15-Nov-07
3rd Quarter 2007	Jul-Sep	15-Feb-08
4th Quarter 2007	Oct-Dec	15-May-08

Validation Process

- ≥ 6 records in the QIO Clinical Warehouse per discharge quarter
- Chart sampling of 5 per quarter for re-abstraction by CDAC
- The validation process is abstraction validation, not care provided validation
- Option to request reconsideration if match is $<80\%$

Public Reporting on Hospital Compare




HHS - Hospital Compare - Microsoft Internet Explorer

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Hospital Compare - A quality tool for adults, including people with Medicare

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Welcome to Hospital Compare. This tool provides you with information on how well the hospitals in your area care for all their adult patients with certain **medical** conditions. Hospital Compare was created through the efforts of the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services, and other members of the **Hospital Quality Alliance: Improving Care Through Information (HOA)**. The information on this website has been provided primarily by hospitals that have agreed to submit quality information for Hospital Compare to make public.

This information will help you compare the quality of care hospitals provide. Talk to your doctor about this information to help you, your family and your friends make your best hospital care decisions.

Attention Hospitals: The next refresh of the data displayed in Hospital Compare will be September 20, 2007. If the demographic information for your hospital has changed, please provide the correct information to your **State Survey Agency ASPEN Coordinator** no later than August 17, 2007.



Public Reporting Deadlines

Discharge Quarter		Data Submission Deadline ¹	HQA Preview Report released ^{1 2}	Hospital Compare data released ¹
Previous Quarters				
Q4-2006	Oct-Dec 06	May 15, 2007	Jul 07	Sep 07
Q1-2007	Jan-Mar 07	Aug 15, 2007	Oct 07	Dec 07
Q2-2007	Apr-Jun 07	Nov 15, 2007	Jan 08	Mar 08
Q3-2007	Jul-Sep 07	Feb 15, 2008	Apr 08	Jun 08
Q4-2007	Oct-Dec 07	May 15, 2008	Jul 08	Sep 08
Q1-2008	Jan-Mar 08	Aug 15, 2008	Oct 08	Dec 08
Q2-2008	Apr-Jun 08	Nov 15, 2008	Jan 09	Mar 09
Q3-2008	Jul-Sep 08	Feb 15, 2009	Apr 09	Jun 09
Q4-2008	Oct-Dec 08	May 15, 2009	Jul 09	Sep 09
Q1-2009	Jan-Mar 09	Aug 15, 2009	Oct 09	Dec 09
Q2-2009	Apr-Jun 09	Nov 15, 2009	Jan 10	Mar 10
Q3-2009	Jul-Sep 09	Feb 15, 2010	Apr 10	Jun 10



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RHQDAPU

- Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Initiative
 - Initially developed as a result of the MMA of 2003. The DRA of 2005 set out new requirements for the RQHDAPU program
 - PURPOSE: Equip consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients

FY2008 RHQDAPU

- Reasons hospitals did not qualify for the full annual payment update
 - Failed to sign and submit the FY 2008 Pledge of Participation form
 - Failed to submit complete data by the posted submission deadlines
 - Failed to participate in either HCAHPS Survey Dry Run, or submit a letter to CMS stating hospital had no HCAHPS-eligible discharges
 - Failed to meet validation requirements

Getting control of RHQDAPU

Don't run from RHQDAPU,
gain control



The POWER OF KNOWLEDGE!

RHQDAPU Knowledge

- Ways to gain RHQDAPU knowledge and understanding
 - CMS website
 - QualityNet website
 - HCAHPS website
 - Hospital Compare website
 - QIOs and HRP QIOSC staff

QNE Reports~Reports Viewer

QualityNet Exchange - Microsoft Internet Explorer

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Hello, **Rynda Westendorf** from **IA/IL QIO**
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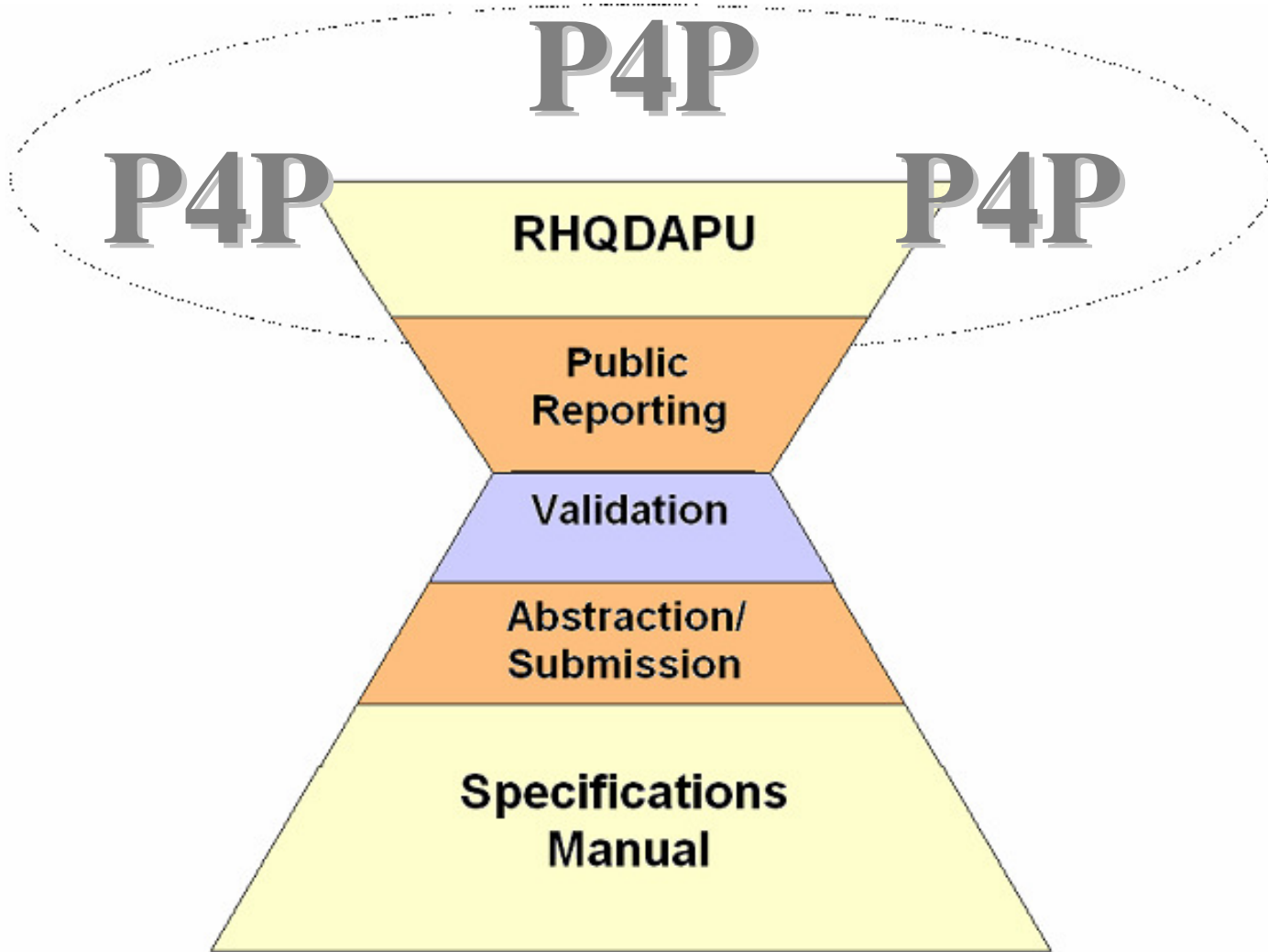
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QualityNet Help Desk 7 a.m. - 7 p.m. CT Monday - Friday
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Hospital Readmissions: Monitoring Data for Payment Error and Quality

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This material was prepared by TMF Health Quality Institute, the Quality Improvement Organization Support Center for the Hospital Payment Monitoring Program, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. 8SOW-TX-HPMPQ-08-01



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Objectives

- Discuss how hospital readmissions may be related to compliance and quality of care issues
- Learn about potential billing errors related to hospital readmissions
- Learn how analyzing hospital readmission data can support auditing and monitoring efforts
- Discuss actual readmission case examples

Readmissions as a Compliance Focus

- Hospital readmissions can be an indication of:
 - Quality of care issues
 - Billing errors

Readmissions and Quality of Care

- Circumvention of PPS: Prohibited Actions
 - Premature discharge of a patient that results in subsequent readmission of patient to same hospital. Patient is discharged even though he/she should have remained in hospital for further testing or treatment; not medically stable at time of discharge
 - Readmission for care that could have been provided during first admission
 - Leave of absence billing (see Medicare Claims Processing Manual, Chapter 3, sections 40.2.5 and 40.2.6)

Readmissions and Quality of Care

- Circumvention of PPS: Prohibited Actions, cont.
 - Inappropriate transfer of a patient from IPPS unit to IPPS-excluded unit in the same hospital
 - Inappropriate transfer of a patient from a IPPS-excluded unit to a IPPS unit in the same hospital

Readmissions and Billing Errors

- Billing to incorrect provider number
- Inappropriate patient status codes
- Same-day same-hospital readmission

Condition Code B4

- Regulation implemented Jan. 1, 2004
 - Condition Code (CC) B4:
 - If a same-day readmission to the same IPPS hospital is “for a symptom related to, or for evaluation/management of, the prior stay’s medical condition,” the two claims are related and paid as a single claim.
 - If the readmission is for an unrelated symptom, hospitals include CC B4 on the readmission claim; both claims are paid in full.

CC B4 as a Compliance Risk

- Data analysis of hospital use of CC B4 indicated*:
 - 12.8% of all same-day, same-hospital readmissions had CC B4 and DRGs that were probably related or were for rehabilitation
 - 6.8% had the same DRG or CC-paired DRGs for both the initial and the readmission claims
- Currently no regulatory oversight exists
- Represents a potential compliance risk
 - How does your hospital use CC B4?
 - Monitoring in place to ensure correct application?

*Data analysis results to be submitted for publication

Identifying Hospital Readmissions

- Hospitals can produce case listings of readmissions using their management information system
 - Identify patients readmitted within seven days
 - Produce report which includes patient identifier, admission and discharge dates, patient status codes, DRG, principal diagnosis, and LOS
 - Sort by patient identifier, in discharge date order
- TMF identified readmissions to the same hospital within seven days of discharge

Readmission Case Listing

Potential Problem	Admit Date	Discharge Date	Discharge Status	DRG	Principal Diagnosis
Prohibited Action ? (LOA)	4/11/2007	4/15/2007	01-Home	138: Cardiac Arrhythmia & Conduction Disorders w/o CC	4271-paroxysmal vent. tachycardia
	4/19/2007	4/22/2007	06-Home Health	555: Percutaneous Cardiovascular Proc w/ Major CV Diagnosis	4271-paroxysmal vent. tachycardia
Prohibited Action ? Billing? Quality?	4/27/2007	4/29/2007	01-Home	002: Craniotomy > 17 w/o CC	99709-surg compl of nervous system
	5/3/2007	5/7/2007	01-Home	002: Craniotomy > 17 w/o CC	99709-surg compl of nervous system
Billing?	11/29/2005	12/7/2005	62-Inpt. Rehab (or distinct part unit)	113: Amputation for Circ. System Disorders Exc. Upper Limb & Toe	44020-atherosclerosis of native artery
	12/7/2005	12/15/2005	02-Short-term Hospital	462: Rehabilitation	V5789-rehabilitation procedure

Readmission Case Listing

Potential Problem	Admit Date	Discharge Date	Discharge Status	DRG	Principal Diagnosis
Billing? (CC B4)	12/20/2005	12/23/2005	06-Home Health	079: Respiratory Infections and Inflammation > 17 w/CC	5070-food/vomitus pneumonitis
	12/23/2005	12/26/2005	06-Home Health	557: Percut. Cardiovasc. Proc. w/Drug Eluting Stent w/ Maj CV Dx	41011-AMI, ant. wall, initial
Billing? (CC B4)	2/8/2006	2/9/2006	01-Home	124: Circ. Disorders Exc. AMI w/Cardiac Cath & Complex Dx	41400-coro. atherscl, unspec vssel, ntv/graft
	2/9/2006	2/11/2006	01-Home	558: Percut. Cardiovasc. Proc. w/Drug Eluting Stent w/o Maj CV Dx	41401-coro. atherscl, native vessel
Quality? (Premature Discharge)	5/29/2006	6/2/2006	01-Home	320: Kidney and UTI > 17 w/CC	5990-urinary tract infection
	6/7/2006	6/9/2006	20-Expired	318: Kidney and Urinary Tract Neoplasms w/CC	1889-malignant neoplasm, bladder

Analyzing Hospital Readmission Data

- Potential prohibited actions
 - Patient readmitted for procedure that should have been completed during first admission, or the bill should have been billed “leave of absence” (“furlough”)
- Potential billing errors
 - Are patients being discharged to other distinct parts (units such as rehab, psych, SNF) but claim billed using acute-care number?
 - Are patient status codes on the index admission claim correct?
 - Potential application of condition code B4
 - When to use it, how to use it correctly
- Potential quality of care issues
 - Patient readmitted with same or similar condition
 - Does documentation suggest patient was discharged prematurely?

Readmissions: An OIG Concern

- Four OIG Reports (1999-2002)
- CY 1996 same-day same-hospital
 - Random sample of 100
 - 29 error claims
 - 12 of 29 premature discharge—“quality of care”
- CY 1997 multiple continuous admissions
 - 73 beneficiaries with 3 or more multiple, continuous admissions
 - One beneficiary readmitted 5 times, 6 full DRG payments

Readmissions: An OIG Concern

- CY 1996-1998
 - Discharged as LAMA (left against medical advice)
 - Miscoded PPS transfer (07 instead of 02)
 - Both receive full DRG payment
- CY 1998
 - Discharged from acute-care to distinct part unit (SNF, rehab)
 - Distinct part unit admission billed incorrectly using acute-care provider number

Compliance Plan for Readmissions

- Identify readmissions
- Review medical records
- Focus on problem areas
- Auditing and monitoring
- Track and trend over time
- Opportunities for process improvement
- Opportunities for policy evaluation and revision
- Education and training

Case Example #1 – Billing Error

- 69-year-old female admitted for total knee replacement. Following surgery, the patient was stable and the physician recommended a course of inpatient rehabilitation. The hospital transferred the patient to their rehabilitation unit.
- Hospital billed the rehabilitation admission to the hospital's acute care provider number
- Findings: this admission should have been billed to the hospital's rehabilitation distinct part unit provider number.

Case Example #2 – Prohibited Action

- 72-year-old male with history of severe CHF was admitted with cholelithiasis, for cholecystectomy. Due to scheduling conflicts with the OR, the surgery had to be delayed. The patient was admitted three days later for the procedure, which was completed with no complications.
- The hospital billed these as two separate admissions, and received two separate DRG payments.
- Findings: the hospital should have used the “leave of absence” billing procedure and received one DRG payment.

Case Example #3 – Quality of Care

- 72 year-old female, bedridden, with hx of ASHD, CHF, renal insufficiency, admitted with dehydration. Labs revealed sodium of 119, potassium 5.5, BUN 50. UA was positive for nitrates. Patient was treated with IV abx, IV normal saline at 40 cc/hr., and continuation of home medications. On day two, sodium level was 122. On day four, patient was discharged home on home meds and abx.
- Two days later, the patient presented back to the ED with lethargy, weakness, & diarrhea. Sodium was 120. She was admitted to rule out SIADH, adrenal insufficiency, and hypothyroidism.
- Findings: the physician did not appropriately address the sodium of 119 on the first admission; failed to develop an appropriate treatment plan; did not provide rationale for prescribing Lasix q 12 hours or for not re-evaluating sodium level. Failed to ensure patient was stable at discharge.

Case Example #4 – Quality of Care

- 77-year-old male with hx of colon cancer, hypertension, CAD with stent placement was brought to the ED from the radiology dept; during an outpatient MRI, patient lost the ability to speak. Patient had complained of slurred speech and dizziness for last 2 days. CT scan of brain was negative. CXR revealed enlargement of cardiac silhouette, LLL pneumonia, and changes suspicious for effusion. Patient underwent L renal angioplasty with stent placement to treat stenosis. Patient was discharged home.
- Two days later, patient returned to the ED with chills, SOB, weakness. CXR revealed worsening LLL pneumonia, WBC were elevated.
- Findings: the physician failed to address the abnormal CXR showing LLL pneumonia, and failed to ensure stability for discharge.

Case Example #5 – Quality of Care

- 76-year-old female admitted with aphasia, weakness with unsteady gait, garbled speech. ECG and telemetry showed sinus rhythm. On 2nd day, patient went into atrial fibrillation and flutter, physician notified. Patient was discharged that day due to her husband's death. Discharge summary states patient had regular rate & rhythm.
- The same day, patient returned to the ED with SOB, dizziness, palpitations, and chest pain. ECG showed atrial fibrillation with rapid ventricular rate. Patient was started on IV digoxin and admitted.
- Findings: the physician failed to assess and act on the abnormal telemetry strips, failed to ensure stability for discharge.

Resources/References

QIO Responsibilities

Social Security Act, Section 1154 (a) (13) [42 U.S.C. 1320c-3]

http://www.ssa.gov/OP_Home/ssact/title11/1154.htm#act-1154-e

42 CFR 476.71 (a) (8) (ii)

http://a257.g.akamaitech.net/7/257/2422/13nov20061500/edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr476.71.pdf

42 CFR 412.48 (a) (1); (c)

http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr412_06.html

QIO Manual

Chapter 4: Case Review

Sections 4105 Quality Review, 4240 Readmission Review, 4250 Transfer Review, 4255 Circumvention of Prospective Payment System

<http://www.cms.hhs.gov/manuals/downloads/qio110c04.pdf>



Resources/References

Medicare Claims Processing Manual

(CMS Publication 100-04)

Chapter 3: Inpatient Part A Hospital

40.2.4 IPPS Transfers Between Hospitals, 40.2.5 Repeat Admissions, 40.2.6 Leave of Absence

<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>

CMS Instruction to Fiscal Intermediaries

(Same-day, same-hospital readmissions)

CMS Transmittal 266/Change Request 3389/Medlearn Learning Network MLN Matters #MM3389

(Same-day, different hospital readmissions)

CMS Transmittal 87/Change Request 2934/MLN Matters #MM2934

<http://www.cms.hhs.gov/Transmittals/2004Trans/List.asp>

Resources/References

Office of Inspector General Reports

Monitoring Quality of Care and Overpayment Issues Associated With Hospital Readmissions Under the Medicare Prospective Payment System (A-01-98-00504);

<http://oig.hhs.gov/oas/reports/region1/19800504.pdf>

Analysis of Readmissions Under the Medicare Prospective Payment System for Calendar Years 1996 and 1997 (A-14-99-00401);

<http://oig.hhs.gov/oas/reports/hcfa/b9900401.pdf>

Medicare Prospective Payment System Transfers Reported As Left Against Medical Advice Hospital Discharges (A-06-99-00045);

<http://oig.hhs.gov/oas/reports/region6/69900045.pdf>

Review of Medicare Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During Calendar Year 1998 (A-03-01-00011)

<http://oig.hhs.gov/oas/reports/region3/30100011.pdf>



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Analyzing and Integrating Data From Compliance Audits To Improve Quality of Care

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Government Focus on Quality of Care

- Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors
 - OIG and American Health Lawyers Association (AHLA) co-sponsor 9/13/07
 - Duty of care/duty of obedience
 - Defines quality of care
 - Boards called to respond to clinical, operational and regulatory developments associated with quality of care



Government Focus on Quality of Care

- Compliance and the Quality of Care Revolution: Fitting the Pieces Together in the Government's New Enforcement Landscape
 - AHLA Health Lawyers News (Wagonhurst, Anderson, Rifenbark and Lackman) 9/07
 - Survey of government quality of care enforcement approaches and data mining techniques
 - Guidance on how to integrate quality into compliance programs

Government Focus on Quality of Care

- Board Oversight and Quality of Care Issues: A Review of OIG/AHCA White Paper
 - HCCA “Compliance Today” (Rifenbark, Anderson, Wagonhurst) 10/07
 - Overview of OIG/AHCA publications

Enforcement of Quality of Care

- False Claims Act
 - The government should not pay for care that is either medically unnecessary or substandard
 - Poor quality = unnecessary services
- Data Mining
 - Hospital Compare
 - PEPPER (Program for Evaluating Payment Patterns Electronic Report)
 - CERT (Comprehensive Error Rate Testing)
 - PERM (Payment Error Rate Measurement)
 - RAC (Recovery Audit Contractors)

Integrating Quality Into Baptist Health Compliance

- Baptist Health
 - Largest system in Arkansas
 - 2 acute care hospitals
 - 1 inpatient rehabilitation hospital
 - 2 critical access hospitals
 - Multiple outpatient services
 - Physician practices
 - Diploma nursing school



Integrating Quality Into Baptist Health Compliance

- Annual Implementation Plan
 - Input
 - Senior leadership, OIG Work Plan, Corporate Compliance Committee, legal counsel, fiscal intermediary, QIO “hot topics”
 - Approval
 - Finance & Audit/ Executive Committee of Board of Trustees
 - Reporting
 - Quarterly to the Board

Integrating Quality Into Baptist Health Compliance

- Quality Review Committee
 - Membership
 - Monthly reporting
 - Focus of reviews-medical necessity, utilization review, risk management, patient safety, infection control, etc.
 - Financial/Performance Outcomes
 - Quality Agenda
 - Safety
 - Timeliness and efficiency
 - Effectiveness
 - Customer centered
 - Information Resources
 - Internal chart audits and customized reports
 - External reports from QIO and Hospital Compare



Baptist Health Quality Audits

- Compliance with Peripherally Inserted Central Catheter (PICC) protocols
 - QRC approved
 - Random sample
 - Audit of protocols—nursing education, dressing-injection cap-tubing changes, removal practices
 - Documentation requirements—consents, progress notes, orders, radiology report
 - Audit results and recommendations
 - Training
 - Documentation
 - On-going quarterly self-audits

Baptist Health Quality Audits

- Expected Impact on Quality of Care
 - Ensure correct placement of PICC line
 - Decrease potential for infection/complications
 - Ensure appropriate removal of PICC line
 - Ensure adequate follow up care per discharge disposition

Baptist Health Quality Audits

- Medical Necessity of Inpatient Rehabilitation Facility (IRF) Admissions
 - Medicare Benefit Policy Manual, LCD
 - Documented evidence
 - Criteria met
 - Medical supervision
 - 24 hour rehabilitation nursing
 - Therapy hours
 - Interdisciplinary team approach
 - Reasonable expectation of practical improvement
 - Short and long-term goals
 - Appropriate cessation of services
 - Audit results and recommendations
 - Education regarding documentation
 - Team Conference reporting process
 - Pre-admission assessments

Baptist Health Quality Audits

- Expected Impact on Quality of Care
 - Ensure appropriate admissions
 - Ensure length of stay is commensurate with practical improvement
 - Ensure appropriate discharge to lesser level of care

Baptist Health Quality Audits

- Medical Necessity of Cataract Surgery
 - LCD, NCD, Medicare Benefit Policy Manual, Social Security Act Section 1862
 - Documented evidence
 - Standardized formal measurement of visual functional status
 - Pre-ophthalmologic evaluation
 - Informed consent
 - Expected improvement
 - Bilateral surgery not on same day
 - Support of surgical level billed
 - Audit results and recommendations
 - Standardized H&P
 - Ensure use of informed consent form

Baptist Health Quality Audits

- Expected Impact on Quality of Care
 - Ensure cataract surgery is medically necessary
 - Ensure bilateral cataract surgery does not occur on same date of service

Key Principles

The government should not pay for care that is either medically unnecessary or substandard

Policies, procedures and protocols must support best practices

Ongoing monitoring of quality of care requires an active self-auditing program

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