Tackling Readmission Denials

Reggie Allen, MBA, RN, ACM

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- AMEDCO: CME for physicians
- Association of Clinical Documentation Improvement Specialists (ACDIS): Certified Clinical Documentation Specialist (CCDS)
- National Association of Healthcare Revenue Integrity (NAHRI): Certification in Healthcare Revenue Integrity (CHRI)
- Commission for Case Manager Certification (CCMC): CCM board certified case managers
- American Health Information Management Association (AHIMA): Certified health information management professionals
- American Nurse Credentialing Center (ANCC): Continuing nursing education

  This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

CE Language (for physicians)

Association for Healthcare Denial & Appeal Management

Tackling Readmission Denials

July 24, 2024

Online

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AMEDCO: Learner Notification (for physicians)

Association for Healthcare Denial & Appeal Management

Tackling Readmission Denials

July 24, 2024 Online

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No financial commercial support was received for this educational activity.

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Objectives - After Attending This Program You Should Be Able To

1. Identify at least three of the conditions included in the Hospital Readmission Reduction Program from the Centers for Medicare and Medicaid Services.
2. Identify one circumstance when a readmission may have been appropriate.
3. Identify one method of defending appropriate readmissions through the appeals process.

AMEDCO: Learner Notification, continued (for physicians)

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All of these relationships were treated as a conflict of interest,and have been resolved. (C7 SCS 6.1-6.2, 6.5)

All individuals in a position to control the content of CE are listed below.

Name	Commercial Interest:Relationship
Reggie Allen	NA
Karla Hiravi	NA
Alice Pompton	NA
Jo Shultz	NA

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Learning Outcomes

Learning Outcomes: At the conclusion of the webinar, the learner will be able to:

1. Identify at least three of the conditions included in the Hospital Readmission Reduction Program from the Centers for Medicare and Medicaid Services
2. Identify one circumstance when a readmission may have been appropriate
3. Identify one method of defending appropriate readmissions through the appeals process

Learning Objectives for Nurses

At conclusion of the webinar, at least 90% of participants will share on the evaluation:

1. Identification of at least three of the conditions included in the Hospital Readmission Reduction Program from the Centers for Medicare and Medicaid Services
2. Identification of one circumstance when a readmission may have been appropriate
3. Identification of one method of defending appropriate readmissions through the appeals process

This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Reggie Allen, MBA, RN, ACM

Reggie Allen, MBA RN ACM, is the Chief of Clinical/Business Operations for PayerWatch. Reggie has more than 35 years of experience in a variety of healthcare positions, including staff nurse, nurse manager, Chief Nursing Officer, Chief Operating Officer, and Vice President, Clinical/Business Operations Transformation. He has been recognized nationally as an expert in care management and clinical operations. He is a results-driven leader who emphasizes operational transformation by integrating clinical and financial care aspects. He obtained a bachelor's degree in nursing from Vanderbilt University and an MBA from the University of Phoenix. He is a member of the American Case Management Association (ACMA) and the American College of Healthcare Executives.

Reggie possesses comprehensive knowledge and experience in all facets of care management, including case management, utilization management, disease management, quality management, and resource management. He has designed and implemented an enterprise-wide Clinical Appeals Unit and a clinical documentation program with success. Using six sigma and Lean principles, he is an expert in clinical and operational efficiencies that enhance clinical outcomes and financial performance through a variety of methodologies.

Hospital Readmissions Reduction Program (HRRP)

- **What**? HHRP is a Medicare value-based purchasing program that reduces payments to hospitals for excess re-admissions set forth under Section 1886 (q) of the Social Security Act. Program started October 1, 2012.
- **Goal: Improve health care by linking payment to quality of care**. Hospitals are encouraged to improve communication and care coordination to better engage patients and caregivers in post-discharge planning
- **How?**
  - CMS calculates the payment reduction, ranging from 0 to 3% for all HRRP-eligible hospitals
  - CMS applies the payment reduction to all Medicare fee-for-service base operating diagnosis-related group payments regardless of condition or procedure.
- **Patient Types**
  - Medicare fee-for-service stays
  - Medicare and managed care stays with dual eligibility

History of Readmissions

www.cms.gov (Guide for Reducing Disparities in Readmissions)

Facility Inclusion Criteria

- CMS includes all subsection (d) hospitals with eligible discharges for any of the readmission measures in HRRP.
- Hospitals are short-term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS).

Facility Exclusion Criteria

- CMS - Subsection (d) hospital exclusion facility and units
  - Critical Access hospitals
  - Rehabilitation Hospitals and units
  - Long-term care hospitals (LTACs)
  - Psychiatric hospitals and units
  - Children's hospitals
  - Prospective Payment System (PPS) – exempt cancer hospitals
  - Veterans Affairs medical centers and hospitals
  - Short-term acute care hospitals in US territories (American Somoa, Guam, Northern Mariana Islands, Puerto Rico, and the U. S. Virgin Islands)
  - Religious non-medical health care institutions
- Maryland Hospitals are exempt from payment reductions under HRRP due to their participation in Maryland's Total Cost of Care Model. CMS publicly reports readmission measure results for Maryland hospitals, and Maryland hospitals receive a Hospital-Specific Report.

Readmission Measures

Below are the following condition/procedure-specific 30-day standardized unplanned readmission measures

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease) (COPD)
- Heart Failure (HF)
- Pneumonia
- Coronary Artery Bypass Graft (CABG) Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)

Readmission Penalties - CMS

- The measures assess **all-cause unplanned readmissions** that occur within 30 days of discharge from the index (i.e., initial) admission.
- The measures collect data on patients who are readmitted to the same hospital, or another applicable acute care hospital, for any reason.
- The Hospital Readmissions Reduction Program considers all readmissions within 30 days of discharge an adverse event, regardless of the principal diagnosis.
- CMS applies the adjustment factor to all Medicare discharges in the applicable fiscal year, regardless of the condition.

Penalties for FY 2023

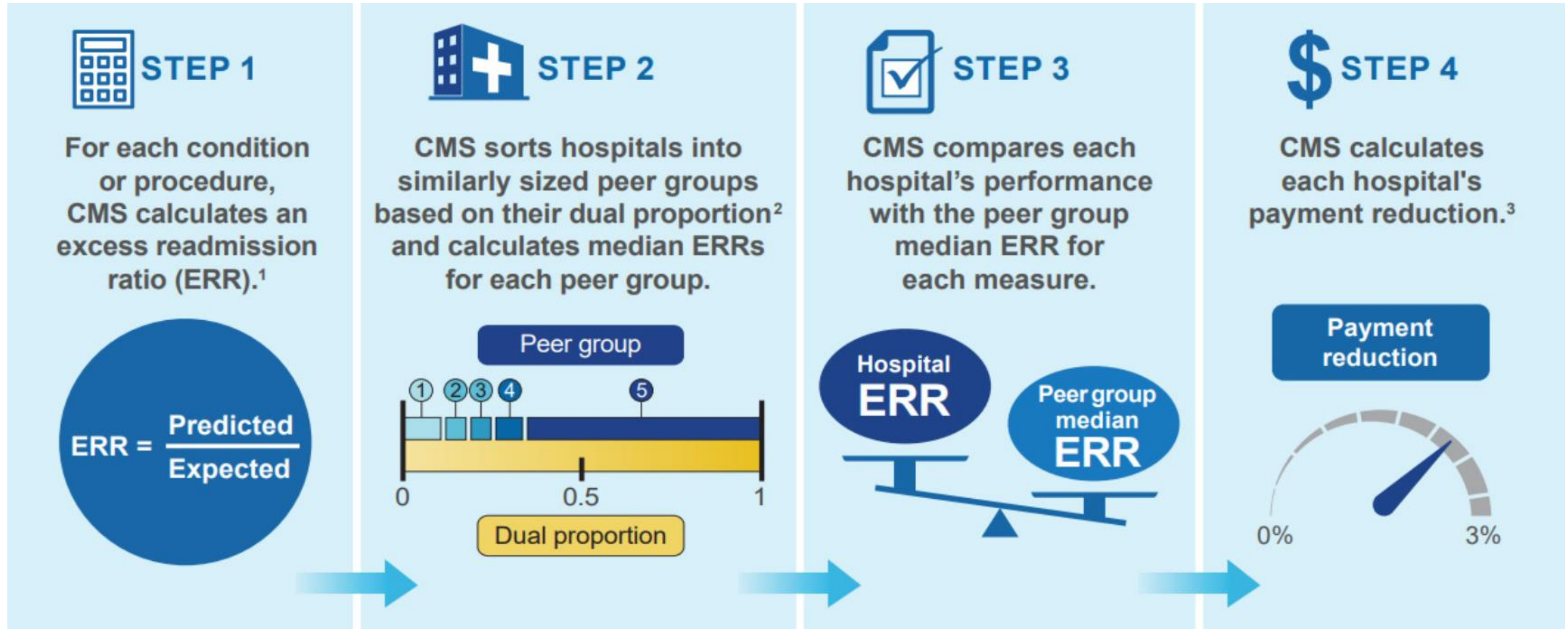
- According to Advisory Board, 2,273 hospitals facing penalties, lower than the past 10 years
- CMS withholds 3% of regular reimbursements for hospital than have a higher-than-expected number of 30-day readmissions for any of six conditions
- The average payment reduction is 0.43%, the lowest since 2014 and cost of $320 million over the next year
- 25.33% of the hospitals will not receive readmission penalties. The number of hospital that have to pay penalties over 1% has dropped by over 50% from 543 in FY2022 to 231 in FY2023.

Source: https://www.advisory.com/daily-briefing/2022/11/04/hrrp-penalties

Penalties for FY 2024

- Impacted by the nationwide Extraordinary Circumstance Exception (ECE) in response to the COVID-2019 public health emergency – excluding claims January 1st through June 30th of 2020 – (29 months instead of 36 months)
- Performance period include claims 30 days before July 1, 2019 to December 1, 2019 and July 1, 2020 and June 20, 2022.
- CMS added back pneumonia after pausing for FY2023 payment for COVID-19's substantial impact (improved coding practices, fewer COVID admissions, sufficient data to make technical updates to the measure specifications)

HRRP Payment Reduction Overview



Key Drivers of Re-Admissions

- Unclear and Noncompliance to Discharge Instructions
- Complications from the Treatment from the First Admission
- Lack of Primary Care Providers
- Language Barriers
- Health Care Literacy
- Culturally Competent Patient Care Education
- Restricted Access to Socioeconomic Resources
- Mental Health
- Advanced Chronic Disease Process/Comorbidities
- Nonrelated Visit

Readmission – Commercial and Medicare Advantage Plans

- Medicare Advantage – Typically follow CMS guidance on readmissions. However, refer to the contract or provider manual
- Does not allow separate reimbursement for claims that have been identified as a readmission to the same hospital for the same, similar, or related condition. This includes facilities under the same provider number

Readmission – Commercial Plans
BlueCross Blue Shield (as an example)

Inpatient readmission criteria may include, but are not limited to:

- The same or closely related condition or procedure as the prior discharge.
- An infection or other complication of care.
- A condition or procedure indicative of a failed surgical intervention.
- An acute decompensation of a coexisting chronic disease.
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post-discharge follow-up period.
- An issue caused by a premature discharge from the same facility.

Readmission – Commercial Plans
BlueCross Blue Shield (as an example)

Inpatient readmission review does NOT include:

- Admissions for the medical treatment of cancer, primary psychiatric disease, transplants and rehabilitation care
- Planned readmissions
- Member transfers from one acute care hospital to another
- Member discharged from the hospital against medical advice on initial admission
- Maternity and neonatal readmissions

Readmission – Commercial Plans
United Healthcare (as an example)

- Same day readmissions for the same or related condition as the initial admission must be combined with the initial admission and reported on the same UB-04 claim form
- Criteria of inclusions and exclusions are the same as BlueCross Blue Shield

Medical Record Review for Readmissions

- The key is what is documented or can be inferred from the medical record
- Starting place is the DISCHARGE SUMMARY to ensure the discharge instructions were clinically appropriate
- Accurate disposition condition
- Diagnoses correspond to work-up and clinical indicators
- Medications comprehensive and clear
- Disposition location is reasonable and explained
- Appropriate follow-up and time frame

Clinically Related

Examples of clinically related readmissions:

- A continuation or recurrence of the reason for the initial admission or closely related condition.
- An acute decompensation of a chronic problem that was not related to the initial admission but was plausibly related to care either during or immediately after the initial admission.
- An acute medical complication plausibly related to care during the initial admission.
- An unplanned surgical procedure to address a continuation or a recurrence of the problem causing the initial admission.
- A surgical procedure to address a complication resulting from care during the initial admission.

Potentially Preventable

It's not potentially preventable if the documentation supports:

- An appointment was made within the first week or within an appropriate time frame after discharge from the initial admission
- Appropriate telephone numbers were given to the patient for calls to the hospital or primary care provider for related discharge questions
- A health care advocate/provider conducted an in-home safety assessment and/or appropriate follow up as needed
- Written discharge instructions were provided and explained to the patient/caregiver prior to discharge
- All required prescriptions were given to the patient and the patient was educated in the appropriate use of the medication

Potentially Preventable, continued

- Right diagnoses from clinical indicators and the correct work-up and treatment
- If risky treatments/medication, documentation reflect that the consultants done the appropriate risk assessment and rendered a decision
- Documentation that the patient improved sufficiently and was ready for discharge and comorbidities stable at the time of discharge
- If suboptimal disposition, documentation as to why
- Durable medical equipment had been arranged for the patient and the patient had been appropriately educated on its use
- All salient financial and social needs of the patient were addressed

Formulating Your Argument

Pay attention to the Payer’s policy

- What facilities are included/excluded?
- Which conditions/diagnoses are included? All of them?
- What’s the timeframe between admissions to be considered a readmission?
- Readmission to same hospital or any hospital?
- Exclusions to the policy? AMA, transfer, etc.?

Did the payer follow their own policy?

Formulating Your Argument

Clinically related:

- Were the DRGs/primary diagnoses different or related?
- Did the focus of care differ for each admission?

Potentially Preventable:

- Was discharge planning, completion, and follow-up conducted appropriately?

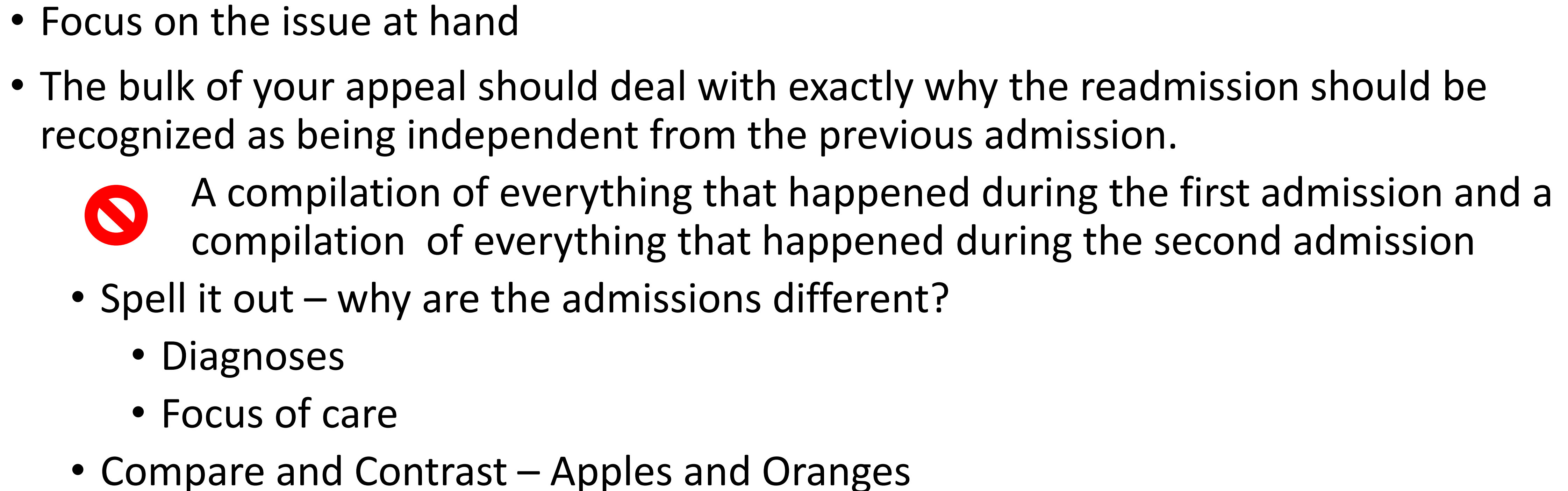
Early Discharge

- Was the patient asymptomatic and comorbidities stable at the time of discharge from the first admission?

Clinically Related Considerations

- Be exceptionally clear about events that happened in the first admission versus the second admission
- Provide the road map
- John Doe was discharged within the past 30 days from an inpatient admission with a diagnosis of __________________ (History and Physical, p. 38). The discharge date was 3/14/2023. On 3/30/2023 John Doe was readmitted as an inpatient with a diagnosis of ___________________ (History and Physical, p. 39).

Clinically Related Considerations



- Focus on the issue at hand
- The bulk of your appeal should deal with exactly why the readmission should be recognized as being independent from the previous admission.
  - A compilation of everything that happened during the first admission and a compilation of everything that happened during the second admission
  - Spell it out – why are the admissions different?
    - Diagnoses
    - Focus of care
  - Compare and Contrast – Apples and Oranges

Potentially Preventable Considerations

- Did the documentation support adequate discharge planning, education, physician follow-up and coordination of outpatient care from the first admission?
  - Discharge instructions that use abbreviations like BID, TID, PO, etc. will not be helpful to show a patient was educated adequately.
  - Non-patient friendly discharge instructions can be actively used against you.
  - Layperson language is essential.

Potentially Preventable Considerations

Look for documentation of:

- Telehealth or post discharge phone assessments
- Care management and discharge planning notes beginning from the day of admission
- Interdisciplinary team communication of patient discharge needs
- Communication with community providers and outpatient services prior to discharge
- Disease management education provided to patient and family

Potentially Preventable Considerations

Did the patient leave against medical advice or was the patient non-compliant?

Determining Patient Non-compliance

- Is there adequate documentation that physician orders were appropriately communicated to the patient?
- Is there adequate documentation that the patient/caretaker was mentally competent and capable of following the instructions, and made an informed decision not to follow them?
- Are there any financial or other barriers to following instructions that are new or not known at first discharge?
- Was the non-compliance clearly documented in the medical record?

Were the Admissions Clinically Related? Case #1

Jane Doe was discharged within the past 30 days from an inpatient admission with a diagnosis of **COPD exacerbation**. Discharge date was 9/10/2021.

DRG 192: CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITHOUT CC/MCC

Were the Admissions Clinically Related? Case#1

On 9/20/2021 Ms. Doe presented to the hospital Emergency Department via ambulance after experiencing chest pain, palpitations, and shortness of breath. EMS found her to have a critically high heart rate of 210 that was treated by EMS with adenosine 6 mg and then 12 mg with no improvement. She was cardioverted times three with conversion after the third shock. She was supported with assisted ventilations with bag-mask while receiving treatment by EMS. She was **diagnosed with acute hypoxemic respiratory failure, respiratory acidosis, hypotension, tachycardia, COPD with exacerbation, chest pain and chronic combined systolic and diastolic heart failure.**

DRG 189: PULMONARY EDEMA AND RESPIRATORY FAILURE

Were the Admissions Clinically Related? Case #1

Summary:

Ms. Doe was admitted as an inpatient for further evaluation and treatment of acute hypoxemic respiratory failure, respiratory acidosis, hypotension, tachycardia, COPD with exacerbation, chest pain and chronic combined systolic and diastolic heart failure. Ms. Doe's pulmonary system was supported with BIPAP. Antibiotics started in ED were held with labs not indicating possible infection. This admission Ms. Doe was noted to have supraventricular tachycardia (SVT) prompting her to be brought to ED. The SVT was treated during this hospitalization. The SVT worsened her oxygenation status and led to her acute on chronic respiratory failure with hypoxia and hypercapnia as the main reason for her admission. SVT was not part of her prior admission.

Was the Patient Noncompliant? Case #2

John Doe was discharged within the past 30 days from an inpatient admission with a diagnosis of **osteomyelitis and dry gangrene of the left foot resulting in the amputation of the fourth toe**. The discharge date was 3/8/2022. Prior to this admission, Mr. Doe was treated for osteomyelitis on home IV antibiotics. The home health agency reported **he was not compliant with the treatment plan**. Mr. Doe had a long history of medical noncompliance and poorly controlled diabetes.

DRG 617: AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC

Was the Patient Noncompliant? Case #2

At discharge, home health was set up to assist with home IV antibiotic treatment and wound care. Follow-up appointments were set for visits with primary care, endocrinology, surgery, and infectious disease. The care team agreed to change Mr. Doe's home IV antibiotic from vancomycin (Q12h) to Daptomycin (Q24h) due to Mr. Doe's noncompliance with frequency of home IV dosing.

Was the Patient Noncompliant? Case #2

On 3/22/2022 John Doe was readmitted as an inpatient with a diagnosis of **osteomyelitis at the 4th & 5th metatarsal remnants, worsened gangrene and cellulitis (advanced to the first through third toe)**. Mr. Doe had presented to the hospital emergency department (ED) for evaluation of progressively worsened left foot swelling, redness, and discharge. Mr. Doe requested a below-knee amputation.

DRG 616: AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC

Was the Patient Noncompliant? Case #2

Summary:

The 03/22/2022 admission was not preventable. Mr. Doe had a **long history of medical noncompliance** that resulted in his return to the hospital and the request for the below knee amputation. At the time of discharge following his first admission, Mr. Doe **had an effective post-discharge plan established**. Most likely because of continued noncompliance and the lack of desire to save his foot, Mr. Doe returned to the ED to seek the below knee amputation. Memorial Medical Center provided aggressive treatment to preserve his foot. Mr. Doe chose to not comply with the treatment plan.

Was the Patient Noncompliant? Case #2

Appeal Decision:

The information received and reviewed for admission 03/22/2022 support separate admissions. All discharge planning related to the first admission was appropriate and completed and the second inpatient stay was not preventable. These are considered unrelated, separate admissions.

Frequent Flyers

Please be advised, in accordance with {Payers Name} Reimbursement Policy concerning Inpatient Readmissions, **Hope Hospital did everything reasonable within its control to prevent Jane Doe's readmission** by providing appropriate care consistent with accepted standards in the prior discharge and/or the post-discharge follow-up period.

In this case, Jane Doe's readmission was due to social determinants and factors outside Hope Hospital's control. Specifically, {INSERT PATIENT'S SOCIAL FACTORS/DETERMINANTS}.

Despite this, Hope Hospital complied with {Payers Name} above readmission policy by providing Jane Doe appropriate care consistent with accepted standards. Hope Hospital's actions to mitigate the readmission and best comply with {Payers Name} readmission policy included {INSERT ANY AND ALL ACTIONS ADVENTIST TOOK TO MITIGATE THE READMISSION – EMPHASIZE "providing appropriate care consistent with accepted standards in the prior discharge and/or the post-discharge follow-up period,"}.

Therefore, based on Hope Hospital's actions to mitigate the readmissions and in the interest of fairness toward your insured, Jane Doe, Hope Hospital demands that you consider this claim in compliance with your Inpatient Readmission policy and process it based on its clinical merits.

See Gourley v. State Farm Mut. Auto. Ins. Co., 822 P.2d 374, 377 (Cal. 1991), as modified on denial of reh'g (May 23, 1991).

Avoiding Readmission Denials (Or at Least Making Them Easier to Appeal)

It's all about the documentation.

- Clinically Related: How is the readmission different from the prior admission; admitting diagnoses, focus of care
- Potentially Preventable: Excellent discharge planning and documentation at first admission; evidence of patient non-compliance or unexpected changes in patient's social or financial situation, etc., in readmission
- Early Discharge: Solid documentation of patient's resolution of presenting problems and treatment of comorbid conditions in discharge summary of first admission

Take Away Points

- Know the payer's readmission policy. Did they follow their own policy?
- Ensure the narrative tells the story of the encounter. Focus on detail key decisions and the thought process of the providers to ensure the appeal is clear and focused.
- Make sure medications are clear and the patient/family understand to avoid complications from medication administration.
- Ensure that the diagnosis corresponds to the work-up and clinical indicators
- Ensure the disposition is reasonable or explained if different from the recommendation
- Ensure follow-up appointments are with the right caregiver and right timeframe
- Ensure clear instructions as the reason to seek urgent or emergent medical attention

References

- https://www.qualitynet.org
- https://qualitynet.cms.gov/inpatient/measures/readmission/reducing-readmissions
- https://qualitynet.cms.gov/files/6109394d739d4800220c0f26?filename=FY_2024_HRRP_FactSheet.pdf
- https://qualitynet.cms.gov/files/6151e416edc606002200492d?filename=FY_2024_HRRP_FAQs_v2.pdf
- https://khn.org/news/article/hospital-readmission-rates-medicare-penalties/

Questions and Answers

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Thank you for attending today's event!

For more information, please contact:

info@ahdam.org

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