CMS proposed the framework for the Readmission Reduction Program in the fiscal year (FY) 2012 inpatient prospective payment system (IPPS) proposed rule. Published May 5, the proposed rule gives providers a glimpse into what they can expect when the program takes effect in 2013.

The Readmission Reduction Program will penalize hospitals with high readmission rates. Essentially, CMS will assess the ratio of each hospital’s readmission rate in comparison to the national average for three target conditions: acute myocardial infarction (AMI), heart failure, and pneumonia. If the ratio is greater than one, CMS will reduce the facility’s aggregate Medicare payment.

Although CMS will focus on three conditions for the first year of the program, it plans to expand the number of conditions in subsequent years.

As a way to prepare, hospitals can compare their readmission rate to the national average on CMS’ Hospital Compare website.

Leave of absence

Hospitals may have a higher than expected readmission rate simply because they aren’t properly billing cases that should be a leave of absence. Instead, hospitals are billing them as a new admission, which will trigger a readmission under the new rules, says Kimberly Anderwood Hoy, Esq., CPC, director of Medicare and compliance at HCPro, Inc., in Danvers, MA.

There are cases when an inpatient requires a medically necessary procedure but it cannot be scheduled immediately. If the patient does not require inpatient care and is stable enough to return home, the hospital can place the patient on leave of absence, which allows the patient to return home until the hospital can provide the procedure.

The Medicare Claims Processing Manual, Chapter 1, section 40.2.5, explains how providers can use leave of absence:

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was

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Is your utilization review committee functional or fictional?

It’s not a matter of if your hospital will be audited by a Medicare scrutinizing organization but when, said John Zelem, MD, FACS, senior director of audit compliance and education for Executive Health Resources in Newton Square, PA. Zelem discussed how an effective utilization review (UR) committee can help ensure that a government audit does not identify any noncompliance during the May 17 HCPro audio conference, “The Effective Utilization Review Committee: Best Practices for Compliance.”

Medicare is increasing its scrutiny of providers in order to reduce the Improper Payment Rate to 5.8% by 2013. Medicare is also expecting providers to perform more self-audits to reduce improper payments, Zelem said.

Functions

Most facilities have a UR committee, but not all organizations have a fully functional UR committee, Zelem said. Hospitals will likely have a UR process for screening patient admissions and ongoing stays, but fewer have a committee that meets regularly to review utilization data and trends.

Such was the case at Baptist Hospital East (BHE) in Louisville, KY, according to Gayle Dickerson, MSM, director of patient management services, patient access, and revenue cycle at Baptist, who also spoke during the May 17 audio conference.

BHE’s UR committee meeting was originally a part of the hospital’s peer review meeting, Dickerson said. The problem was that the peer review discussions dominated the conversation and little time was allotted to the UR committee issues. Luckily, the hospital recognized the UR committee’s potential and separated the two groups.

The UR committee still works in conjunction with the peer review committee because there is crossover between the two groups’ objectives. “Much of what comes out of the utilization side tags right into quality performance,” Dickerson said.

Data focus

The following are sample metrics that the UR committee can collect and review:

➤ LOS
➤ Cost per day according to physician
➤ Outliers
➤ One-day stays
➤ Recovery Audit Contractor (RAC) requests
➤ Readmissions

Zelem suggested reviewing the last six to eight quarters of data when reviewing these items. He also encouraged hospitals to review PEPPER reports to identify best practices and areas that are working, as well as where the hospital stands in terms of outlier elements. After identifying outlying areas, the committee can conduct simple audits to determine what caused the hospital to be an outlier and improve processes accordingly.

Members

CMS states in 42 CFR 482.30 (b) that it requires at least two “doctors of medicine or osteopathy” be members of the UR committee. However, a functional UR committee includes more than two physicians.

At BHE, the UR committee includes the following members:

➤ Medical director
➤ Physician advisor
➤ Compliance officer
➤ Finance representative
➤ Case management leadership
➤ Health information management director

After reading this article, you will be able to:

➤ List the data metrics that an effective utilization review committee should regularly review
➤ RAC leadership
➤ Leadership in other key areas (ED, cardiovascular, radiology, rehabilitation, nursing)

Incorporating other leaders in key areas allowed BHE to identify areas for improvement. For example, the hospital saw wide variations in the time it took to get test results back from the cardiologists due to review of results by rotating cardiology groups.

Through the UR committee the hospital set a standard turnaround time for test results. Setting that standard created accountability for the groups. The committee regularly provides each of the groups with reports that indicate whether they are meeting the standard. This is just one example of process improvement as the result of a UR committee, Zelem said.

**Physician participation**

Often, the hardest part of maintaining an effective UR committee is keeping physicians engaged in the process, says Debbie Mackaman, RHIA, CHCO, regulatory specialist for HCPro, Inc., in Danvers, MA.

One of the ways the BHE UR committee keeps physicians interested is focusing on issues that matter to them specifically. After all, the Conditions of Participation tasks the UR committee with reviewing “professional services,” Zelem said.

“It’s a two-way street. While we are looking at hospital flow issues and hospital initiatives, we also have to look at issues that impact the physician practice,” Dickerson said.

For example, the BHE UR committee looks at the hospital’s electronic health record to see whether it is difficult for physicians to access information. If there is some difficulty, the committee examines ways to improve the process and avoid delays.

The UR committee at BHE also presents the physicians with statistics comparing their utilization performance with that of their physician peers. The committee includes data metrics such as:

➤ Response time to ED calls
➤ Delays in documentation impacting status determination
➤ Rounding delays affecting LOS
➤ Improper use of acute care services (i.e., one-day stays and readmissions)

Dickerson and the UR committee discovered that the reports brought out the physicians’ competitive nature. The physicians wanted to know best practices in order to leverage their performance.

The reports have also created dialogue among the medical staff around proper utilization, which has led to the creation of standardized order sets for certain conditions, such as pneumonia.