No Data is Better than Bad Data

Every Measure You Trusted is Wrong

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OBJECTIVES

- Describe the commonly used Utilization Review Measures
- Explain the methods used to calculate these
- Understand the faults in these measures
- Provide accurate way to measure utilization for use by executives

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MEASURES OF CONCERN

- Case Mix Index (CMI)
- Length of Stay (LOS)
- Readmission rate
- Observation rate
- Observation hours
- Denial rate
- DNFB

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FAMOUS QUOTES

"Without data, you're just another person with an opinion." Deming

"No data is better than bad data." Hirsch

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I AM NOT ALONE IN MY SKEPTICISM

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WHAT MATTERS?

- Providing good clinical care
- Make a margin to remain in business (and grow?)
- Ethics and compliance

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WHAT IS LENGTH OF STAY?

- How long the patient spends in the hospital
- Longer LOS means more cost
  - More nursing hours
  - More medication costs
  - More time for doctors to order stuff

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WHAT IS LENGTH OF STAY?

- So, if we shorten LOS we should reduce costs
  - Less nursing hours
  - Less time for doctors to order stuff
  - More room for a new patient
- Hence, C-suite uses LOS as a KPI

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WHOSE LENGTH OF STAY DO WE MEASURE?

- Inpatients
  - Everyone measures this
- But what about Outpatients who use a hospital bed?
  - Surgery patients who stay past PACU
  - Medical patients who are receiving Observation services
  - "Placement" patients
  - Psych patients boarding until bed available

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HOW IS INPATIENT LENGTH OF STAY MEASURED?

- Start of ED visit until leaves facility?
  - Registration time to last RN entry
- Leaves ED until leaves facility?
  - First floor RN note until last RN entry
- Inpatient admission until leave facility?
  - Admission order time until last RN entry
  - Inpatient registration until last RN entry

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HOW LONG IS THIS PATIENT'S LOS?

- In ED at 8 am Monday April 2
- Order for Observation at 11 am April 2
- Order for Inpatient 11 am Wednesday April 4
- Discharge 4 pm Friday April 5

- Choices-
  - 1 day
  - 3 days
  - 4 days
  - 29 hours

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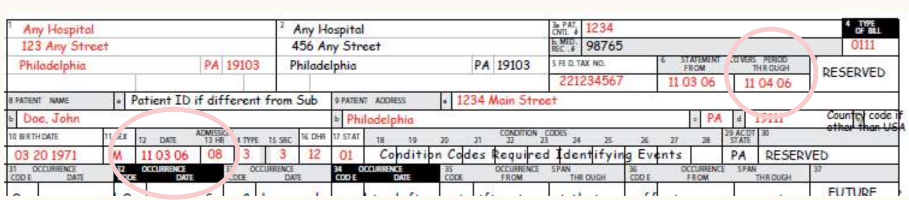
HOW DOES CMS MEASURE LOS?

- Inpatient admission date (Field 12) to through date (Field 6) from UB-04



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MEDPAR DEFINITION

This variable is contained in the following files: MedPAR
Short SAS Name
LOSCNT
SAS Name
LOS_DAY_CNT

The count in days of the total length of a beneficiary's stay in a hospital or SNF.

Source: NCH

Derivations
This field is derived by subtracting the date of discharge (or thru date in SNF cases where beneficiary is still a patient) from the date of admission. If difference is '0,' the value becomes a '1.'

https://www.resdac.org/cms-data/variables/medpar-length-stay-day-count

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HOW MANY DAYS DID PATIENT RECEIVE CARE?

- In ED at 8 am Monday April 2
- Order for Observation at 11 am April 2
- Order for Inpatient 11 am Wednesday April 4
- Discharge 4 pm Friday April 5

- Choices-
  - 1 day
  - 3 days
  - 4 days
  - 29 hours

Do you count the day of discharge???

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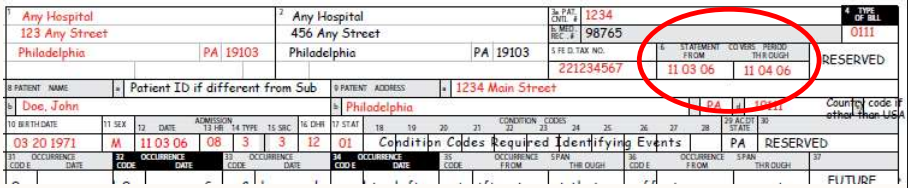
WHAT'S A BETTER WAY TO MEASURE LOS?

- Statement covers from date (Field 6) to through date (Field 6) from UB-04



- Maybe it better captures all the time the patient occupied a bed

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USE THE "STATEMENT COVERS" DATES?

That darn 3 day payment window!

- Scheduled for inpatient colectomy on April 4
- Has pre-op type and screen, CBC, BMP drawn at hospital on April 3
- Arrives at hospital on April 4 8 am
- Surgery April 4
- Discharged April 8

- Choices
  - April 4 to April 8 – LOS 4 days
  - April 3 to April 8 – LOS 5 days

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WHAT SHOULD THE AVERAGE LOS BE?

MS-DRG	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
190	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	1.1230	3.4	4.3
191	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CC	0.8591	2.7	3.3
192	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITHOUT CC/MCC	0.6472	2.1	2.6
329	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	4.5919	9.6	12.5
330	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	2.3637	4.9	6.2
331	SURG	MAJOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	1.6510	2.8	3.3

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WHAT SHOULD THE AVERAGE LOS BE?

- Medical Admissions- 800
- Surgical Admissions- 250
- Avg LOS = 3.8 days

- Medical Admissions- 600
- Surgical Admissions- 500
- Avg LOS = 4.5 days

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WHAT SHOULD THE LOS BE?

- Dec, 2019 – Total Hip inpatient only
  - THA avg LOS = 1.2 days, volume = 400
  - Total inpt surgical volume – 650
  - Overall Surg inpt LOS = 3.8
- Jan, 2020 – Total Hip no longer inpatient only
  - 40% of THA are now outpatient
  - Total inpt volume – 490
  - Overall Surg inpt LOS = 4.5

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WHAT SHOULD THE LOS BE?

Dec, 2023 – Plain old community hospital

Jan, 2024 – Starts transplant and LVAD programs

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WHAT ABOUT THE MONEY?

- Medicare – DRG based payment
  - Same money + lower cost = more "profit"
- Percent of Charges Contract
  - Longer LOS = More charges = More "profit"
- Per Diem Contract
  - Hospital testing/treatment tend to be front-loaded
  - More days on the end = More per diem payments = more "profit"

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LOS LESSON

Trust No One!

Find out how it is measured

Break it down by payer, by patient type

Don't compare apples to tennis balls

Watch for downstream effects of LOS reduction efforts
Higher readmissions – more to come
More SNF usage

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CASE MIX INDEX (CMI) AKA WEIGHT

Assigned to every DRG based on reported cost

MS-DRG	MS-DRG Title	Weights
1	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITH MCC	28.1683
2	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM WITHOUT MCC	9.4045
3	ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS WITH MAJOR O.R. PROCEDURES	21.4316
4	TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS WITHOUT MAJOR O.R. PROCEDURES	14.13
5	LIVER TRANSPLANT WITH MCC OR INTESTINAL TRANSPLANT	10.6494
6	LIVER TRANSPLANT WITHOUT MCC	4.8492
7	LUNG TRANSPLANT	13.0688
8	SIMULTANEOUS PANCREAS AND KIDNEY TRANSPLANT	5.4411

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WHERE WILL CMI GO?

- Hospital with 35% observation rate medical patients (CEO says "It's too high!")
- Institutes secondary review process for all cases that fail screening
- Lowers Observation rate to 25%
- Admissions mainly COPD, pneumonia, medical back pain, non-spec GI disorders (case weight < 1.4)

- What will happen to CMI?
- What will happen to revenue?
- Which one matters more?

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HOW DOES CMS CALCULATE CMI?

CMS assigns a weight to each MS-DRG that reflects the average case cost in that group compared to the average Medicare case cost and uses the same MS-DRG weights for operating and capital payment rates. CMS recalibrates the MS-DRG weights annually without affecting overall payments, based on standardized charges and all IPPS case costs in each MS-DRG. CMS standardizes hospitals' billed charges to improve comparability by:

Adjusting charges to remove differences associated with hospital wage rates across labor markets

Adjusting the sizes and intensity of the hospital's resident training activities

Adjusting the number of low-income hospital patients treated

NOTE: CMS reduces charges to costs using national average hospital cost ratios to charges for 19 different hospital departments.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf

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MEDICARE CLAIMS PROCESSING MANUAL CHAPTER 4

"It is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged."

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84 FR 61221

"We rely on hospitals to bill all CPT codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable, and to report charges on claims and charges and costs on their Medicare hospital cost reports appropriately. In addition, we do not specify the methodologies that hospitals must use to set charges for this or any other service."

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YOUR CHARGEMASTER HAS TO BE OUTRAGEOUS

- If you don't mark up the prices, you suffer the consequences

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HOW WILL YOU PRICE THESE NEW TREATMENTS?

Technology	Add-on Payment
CASGEVY™ (exagamglogene autotemcel); Sickle Cell Disease indication	$1,650,000.00
HEPZATO™ KIT (melphalan for injection/hepatic delivery system)	$118,625.00
LYFGENIA™ (lovotibeglogene autotemcel))	$2,325,000.00

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CONSEQUENCES OF COST REPORTING OMISSIONS

Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion

CPT	Descriptor	SI	APC	Rel Wt	Payment
2019 Addendum B					
22869	Insj stablj dev w/o dcmprn	J1	5116	193.7660	$15,402.46
2020 Addendum B					
22869	Insj stablj dev w/o dcmprn	J1	5115	147.2988	$11,899.00

Several commenters requested that CMS reconsider the proposal to assign CPT code 22869 to APC 5115, and instead allow the code to remain in APC 5116, where it has been historically placed. They believed that the proposal to move the APC was based on inaccurate data, **due to one hospital incorrectly reporting its costs and charges.**

CMS -It is generally not our policy to judge the accuracy of hospital coding and charging for purposes of rate setting.

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OBSERVATION

- Question - What's the right rate?
- Answer - There is no benchmark rate

There is no typical hospital

If you admit patients who should be observation to lower your rate, that is called fraud.

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OBSERVATION

- How do you calculate your observation rate?
  - "Status" at discharge?
  - Any Observation on claim?
  - Are surgical patients included?
  - Are OB labor patients included?
  - What payers are included?

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IS OBSERVATION ALWAYS BAD?

- What are you paid for Observation non-Medicare?
- It's an outpatient so
  - Per diem rate?
  - Fixed APC?
  - Percent of charges?
- Which do you want?
  - $8,000 DRG for 4 day inpatient stay
  - $10,000 for 4 day Obs stay at $2,500 per day, or 70% of $14,000 charges

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WHAT'S YOUR RIGHT OBSERVATION RATE?

1. If every patient is reviewed by case management with the use of a secondary physician review as appropriate for proper admission status,
2. Every patient is placed in the right status,
3. Observation is only ordered on the proper patients,
4. Every patient goes home as soon as their need for hospital care has finished, and
5. Every patient who has medical necessity for a second midnight is admitted as inpatient, then your observation rate is exactly where it should be.

Hirsch's Law

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WHAT'S NOT THE RIGHT OBSERVATION RATE?

Very low- We admit based on a calendar and a crayon; if they're staying we admit 'em!

Zero- We admit everyone and review one day stays and self-deny/rebill the bad ones

Zero- We admit everyone and review one day stays and don't even bother billing the bad ones

Very low- Our EMR inserts "I expect two midnights" on all inpatients so they meet the expectation

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SO WHAT CAN WE DO WITH OBSERVATION?

- Look at short Observation patients
  - Is ED using Observation to beat the throughput clock?
  - Was decision to hospitalize premature?
  - Was decision right but patient improved once upstairs?

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SO WHAT CAN WE DO WITH OBSERVATION?

- Look at Observation length of stay in hours
  - Two classes of Observation patients
    - Fixed LOS – TIA, Syncope- can't get below 24 hours but can aim for 24 hours!
      - Get MRIs and ECHOs read ASAP
    - Variable LOS – all others – get them out when they are better.
      - How long to get a stress test?
      - How long to get that stress test result?
      - Do you discharge if it's dark? If it's 11 pm?

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WHAT ABOUT THE CUSTODIAL CASES?

- "Observation care is a well-defined set of specific, clinically appropriate services…"
- If it is not clinically appropriate, do not bill Observation hours (G0378)
- Bill HCPCS A9270 – custodial care, under rev code 0760
- Can provide ABN and bill patient
- Can now track hours of non-necessary care

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READMISSIONS

- Medicare Hospital Readmission Reduction Program
  - Readmission triggers possible penalty next three years- based on O/E readmit rate
  - Readmission itself paid a full DRG
    - Unless same day, same reason
- Other Payers Readmission Program
  - Whatever the contract you signed lets the payer do
  - Non-contracted MA plans must follow Medicare rules

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READMISSION REDUCTION

- Prevent a readmission to your hospital
  - It's the right thing to do
  - But losing a DRG, likely higher $ than penalty effect of that one admission
  - "Hotspotting" program – super-utilizers in NJ
    - No reduction in utilization
    - "You can't fix a lifetime of problems in 90 days"
    - Are you reporting social determinant Z codes on UB-04?

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READMISSION REDUCTION

- Prevent a readmission to another hospital
  - Probably makes financial sense
    - They get the second DRG, you get penalized
- Aetna now denying readmissions by NPI!
  Others will likely follow
- CMS "aware" MA plans doing this but considers it contractual "for now"

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WHAT DOES YOUR PEPPER SAY? (PEPPER ON HIATUS)

	Readmit to Same	All Readmits	total admits	overall readmit rat	% came back
Q1	400	472	3,516	13.4%	84.7%
Q2	510	604	4,451	13.6%	84.4%
Q3	476	573	3,799	15.1%	83.1%
Q4	425	503	3,450	14.6%	84.5%

	Readmit to same	All Readmits	total admits	overall readmit rate	% came back
Q3	302	482	2,103	22.9%	62.7%
Q4	298	487	2,128	22.9%	61.2%
Q1	281	504	2,077	24.3%	55.8%
Q2	257	424	1,971	21.5%	60.6%

DENIAL RATE

- What are you measuring?
  - Number of denials/all services
    - All inpatient admissions?
    - All services inpt and outpatient?
  - Number of denials/all charts audited

DENIAL RATE

- Payers don't audit "simple" claims
  - DRG w/o CC/MCC
  - Long admissions with no outlier payment
- So if you aren't being audited, is that a good thing?

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LOOK BEHIND YOU!

- Payers hiring external auditors to reaudit approved and paid claims to catch "omissions"

Review Type	What is the "look-back" time frame for the recovery audit?	The Recovery Audit Contract (RAC) will review claims paid by the Office of Community Care from FY18 (10/1/2017-9/30/2018) through FY23 (10/1/2022-9/30/2023).

https://varacinfo.cotiviti.com/Public1/FAQ.aspx

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DNFB – DISCHARGED NOT FINAL BILLED

- Delays in dropping bill
  - Physician queries outstanding
  - Discharge summary not done
  - Pathology result pending
  - Charges not entered
- Can DNFB be shortened without adversely affecting revenue?
  - Can pathology go faster?
  - Will there be more unanswered queries?
  - Will mortality stats worsen if you rush out a claim without review?

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ONLINE FIRST

The Cost of Satisfaction

A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Scan for Author Audio Interview

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N = 51 946) to the 2000 through 2007 national Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2005 subsample (n = 36 428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.9 years.

Results: Adjusting for sociodemographics, insurance status, availability of a usual source of care, chronic disease burden, health status, and year 1 utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit (adjusted odds ratio [aOR], 0.92; 95% CI, 0.84-1.00), higher odds of any inpatient admission (aOR, 1.12; 95% CI, 1.02-1.23), 8.8% (95% CI, 1.6%-16.6%) greater total expenditures, 9.1% (95% CI, 2.3%-16.4%) greater prescription drug expenditures, and higher mortality (adjusted hazard ratio, 1.26; 95% CI, 1.05-1.53).

Conclusion: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.

Arch Intern Med. 2012;172(5):405-411.
Published online February 13, 2012.
doi:10.1001/archinternmed.2011.1662

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WHAT CAN YOU MEASURE?

- Avoidable Days / Avoidable Delays
  - Patient – wants to stay
  - Physician – let's them stay, slow workup, incidentals
  - Hospital – no weekend services
  - External Forces- Insurer, Post-acute provider, Transportation
- Collect data and effectuate change
- Provide feedback – denials, overturns
- Acknowledge high performers!

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SUMMARY

- What are you measuring?
- How are you measuring it?
- Is everyone measuring the same?
- How are you setting your target rate?
- What are the unintended consequences of reaching that target?

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THANK YOU!

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