To Admit or Not to Admit: How Do We Answer this Question?

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ACMA WPA Chapter Conference October 6, 2012
Four Points Sheraton North, Mars, PA
Presentation Outline

• Objectives
• Care Management Models
• Medical Director Support
• Medical Director ROI
• Learning Lessons
Learning Objectives

• Define the strategy for level of care determinations
• Examine two common gaps in care management models and their correlation to readmission/denial rates
• Define the ROI for Medical Director support
Current Definition of Success

1. Episodic approach
2. Manage LOS
3. Control cost?

Inpatient Admissions

Observation Stays

BONUS
The Shape of Things to Come

The shape of things to come

Chronic Care Costs 75%

Acute Care Costs 25%

2010 CDC map showing obesity rates across the United States.
## EXHIBIT 3 | Outcomes-Based Initiatives Are Critical to Managing Medical Costs

<table>
<thead>
<tr>
<th>Outcomes focus</th>
<th>Nationals</th>
<th>Blues</th>
<th>Regionals</th>
<th>Integrated models</th>
<th>Focused-segment plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk transfer and sharing with providers (e.g., ACOs)</td>
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<td>Pay-for-performance</td>
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<td>Collaboration with select providers (narrow networks)</td>
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<tr>
<td>Provider quality initiatives</td>
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<tr>
<td>Traditional mechanisms to manage medical costs(^1)</td>
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<td>Member-focused initiatives(^2)</td>
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<td>Consumer-directed, value-based insurance(^3)</td>
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<tr>
<td>Channeling patients to lower-cost settings</td>
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<tr>
<td>Expanding access to nonphysician providers</td>
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<td>Utilization management</td>
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<tr>
<td>Lowering reimbursement rates</td>
<td></td>
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</tr>
<tr>
<td>Vertical integration with providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Sources:
- BCG survey of payer responses to the Affordable Care Act; BCG interviews.
- \(^1\)Includes disease management.
- \(^2\)For example, providing direct support, including screenings and health coaching, for members to better manage their health.
- \(^3\)For example, structuring incentives for members to manage their health around preventive medicine, healthier lives, and improved compliance.
## Future Hospital Reimbursement More Closely Tied to Performance

<table>
<thead>
<tr>
<th>Payment Driver</th>
<th>Description</th>
<th>Payment Reduction Timeline</th>
</tr>
</thead>
</table>
| **Value-Based Purchasing Program**            | • Mandatory pay-for-performance program assessing 20 quality, satisfaction metrics  
 |                                               | • Percentage of hospital inpatient payments withheld, earned back based on quality performance | • Withholds begin at 1% in 2013, grow to 2% by 2017                                        |
| **Hospital Readmissions Reduction Program**   | • Hospitals with greater than expected readmission rate subject to financial penalty  
 |                                               | • Performance based on 30-day readmission metrics for 3 conditions in 2013, expanding in 2015 to include 4 others | • Penalties capped at 1% of total DRG payments in 2013, 2% in 2014, and not to exceed 3% in 2015 and beyond |
| **Hospital-Acquired Condition (HAC) Penalty** | • Hospitals in bottom quartile of performance relative to national risk adjusted average are subject to financial penalty | • 1% penalty deducted from DRG payment starting in 2015                                   |

- Not just Medicare mandate
- Private payers are accelerating payment innovation
VBP Patient Care Domains

Proposed FY 2014

Efficiency 20%

Process Measures 20%

Outcomes 30%

HCAHPS 30%

Medicare Spending per Beneficiary: Medicare Part A and B claims, 3 days prior to index admission through 30 days post-discharge (hospital specific)

3 Mortality: AMI, HF, PN
8 Hospital Acquired Conditions (HAC):
- Foreign body retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stage III & IV
- Falls and Trauma
- Catheter associated urinary tract infection
- Vascular catheter associated infection
- Poor glycemic control
1 PSI Composite: Pt Safety for Selected Indicators
1 IQI Composite: Mortality for Selected Medical Conditions

2 AMI:
- Fibrinolytic therapy w/in 30 minutes of arrival
- Primary PCI w/in 90 minutes of arrival
1 Heart Failure:
- Discharge instructions
2 Pneumonia:
- ED Blood culture prior to antibiotic
- Initial antibiotic selection
8 SCIP:
- Prophylactic antibiotic 1 hr before incision
- Appropriate antibiotic selection
- Prophylactic antibiotic stopped within 24 hours after surgery
- Cardiac surgery patients with controlled 6am post-op serum glucose
- Urinary cath removal post-op day 1 or 2
- Beta blocker prior to arrival who received beta blocker in the peri-operative period
- VTE prophylaxis ordered
- VTE prophylaxis within 24 hours prior to surgery to 24 hours after surgery

8 HCAHPS:
Nurse communication
Doctor communication
Cleanliness / quietness
Responsiveness of hospital staff
Pain management
Communication about medications
Discharge Instructions
Overall rating

UPMC LIFE CHANGING MEDICINE
## Progressive Financial Impact

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBP</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
</tr>
<tr>
<td>HAC</td>
<td>Reporting</td>
<td>Reporting</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>1.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2.0%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

1% = $7 million*

Total at risk for CMS = $42 million

- Includes the overall impact on Medicare managed care revenues also
Readmission Reduction Program Begins 10/1/12

- Not part of VBP
- Payments in year 2 will be reduced to account for “excess readmissions”
- Specific information regarding the payment adjustment in next year’s IPPS rule (4/2012)
- Excess Readmission Ratio:
  - hospital specific ratio
  - actual readmissions to risk-adjusted expected readmissions
  - **AMI, HF, PN**
  - Hospitals with a ratio of greater than one have excess readmissions relative to average quality hospitals with similar types of patients
- Potential expansion FY15: COPD, CABG, Percutaneous Transluminal Coronary Angioplasty, (PTCA) and other vascular procedures
“Rehospitalizations among Patients in the Medicare FFS program”  Jencks, et al NEJM April, 2009

• 19.6% patients readmitted within 30 days
• 50.2% of these patients had no bill for visit to MD office between the time of discharge and rehospitalization
• 70.5% rehospitalized for medical condition
• 77.6% of readmissions had medical condition on index admit
• 22.4% had surgical condition on index admit
• Top conditions at Index Readmission: HF, Pneumonia, COPD, Psychoses, GI problems
• Estimated 10% of rehospitalizations were planned
• Estimated cost of unplanned readmits: $17.4 billion.
Readmission Focus: Skilled Facilities

- **Root causes:**
  - Poor communication
  - Medication reconciliation
  - Clear post-surgical or complex nursing care instructions
  - Little or no communication between physicians
  - Follow-up appointments never made or communicated
  - Skilled facility not equipped to care for more complex patients
    - Timing of Patient Discharge
      - Interval between DC and readmission: 24-48 hours?
    - SNF vs. Inpatient Rehab for Joint Replacement, CVA
Accountable Care Translates into Payment

Performance Accountability Expanding Across the Care Continuum

- Capitation/Shared Savings Models
- Hospital-Physician Bundling
- Episodic Bundling
- Pay-for-Performance

Care Continuum
Things to Consider........

Old Regime

Admit

Vs.

Not Admit

New World Order

Volume

Accountable Care

Revenue

Patient Risk

Regulatory Risk
What is Care Management’s Role?

RN

SW

MD
UPMC Care Management Models

**UM**
- Nurse responsible for UM
- No responsibility for discharge planning

**UM/DC**
- Nurse responsible for utilization management
- Social worker responsible for discharge planning

**CC**
- Nurse responsible for utilization management and care coordination
- Social worker consulted for complex discharge planning, psycho-social issues, and crisis intervention
Typical Gaps in Care Management models

Are these gaps for you?
Compliance Program Process

Failed Screening Criteria

Additional supporting documentation

Inpatient Admission?

80% of cases???????
No longer appropriate to use all clinical findings to determine level of care. Level of care is determined based on primary clinical condition.
2011 InterQual Condition Specific Criteria

• Adult Acute
  – Acute Coronary Syndrome
  – Asthma
  – Epilepsy
  – Heart Failure
  – Pneumonia
  – Stroke / TIA

• Pediatric Acute
  – Asthma
  – Croup
  – Epilepsy
  – Pneumonia

For the medical patients, InterQual has implemented Condition Specific Criteria that has impacted level of care determinations
2012 InterQual Condition Specific Criteria

• Adult Acute
  – Anemia/Bleeding
  – Arrhythmia
  – COPD
  – Deep Vein Thrombosis
  – Infection: CNS
  – Infection: Endocarditis
  – Infection: GI/GU/GYN
  – Infection: Musculoskeletal
  – Infection: Skin
  – Inflammatory Bowel Disease
  – Pulmonary Embolism
  – Antepartum/Postpartum

• Pediatric Acute
  – Anemia/Bleeding
  – Bronchiolitis
  – Failure to Thrive
  – Gastroenteritis
  – Hyperbilirubinemia
  – Antepartum/Postpartum

InterQual has increased the number of Condition Specific Criteria in 2012 anticipate continued impact on inpatient admissions
Setting the stage for Accountability?

- Strong UR process
  - Documenting level of care determinations
- Appropriate CM staffing
- Tracking avoidable delays
- Tracking of concurrent/retrospective denials
- Tracking of Readmissions
- Tracking of Third Party Audits

**Answer:** We need Medical Director support
What Support Do YOU Have?: Survey Results  
N=56

**PA Support**
- Yes: 93%
- No: 7%

**Track Determinations**
- No: 33%
- Yes: 67%

**Hours**
- 0-10: 24%
- 11-20: 7%
- 21-30: 19%
- 31-40: 12%
- 40+: 38%

**Money**
- Salary: 53%
- Stipend: 11%
- Other: 3%

**Type**
- Internal: 44%
- External: 10%
- Combo: 46%
Possible Roles of the Medical Director

• Medicare/Medicaid
  – Compliance, rules, regulations
  – Integrity Audits
  – Quality Issues
    • Never events
    • Pay for performance

• Commercial Payors
  – Appeals
  – Contract negotiations

• HIM
  – Present on Admission
  – Physician documentation

• Hospital UM/UR
  – Length of Stay
  – Discharge barriers
  – UM committee
  – Dealing with problem physicians

• Revenue Cycle
  – Billing and coding

External?  Vs.  Internal?
Level of Care Determinations

Initial LOC determination by MD

Failed screening criteria

Referral to Medical Director

Final LOC determination

ROI Opportunity

CM Staff

Medical Staff
What is the right decision?

FACTORS TO CONSIDER
Readmission Audit: Days Between Readmissions

SNF A N=20

SNF B N=33
SNF A
- Hospice considered as ALOC (2)
- LTAC considered as ALOC (1)
- Pt refused dialysis (2)
- High % pts were SNF residents
- Readmits in 1-3 days
  - Fall w/ fracture
  - New CVA
- **Avoidable (2)**

SNF B
- Hospice considered as ALOC (1)
- LTAC considered as ALOC (1)
- Acute Rehab considered as ALOC (1)
- High % pts were SNF residents
- High % pts were vent dependent
- Pt CTB on readmit (3)
- Readmits in 1-3 days
  - Family request
- **Avoidable (2)**

Admit or Not to admit
Internal Referrals: Pre & Post External PA Implementation

Avg/Month

Post-External (FY'12)

Pre-External (Jul-Dec)

Time frame: FY’12
## Concurrent Denial Trends: System

(Payers inform Hospital CM that care for a current inpatient is denied).

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total “Threatened Days” *</td>
<td>11,869</td>
<td>14,896</td>
<td>21,567</td>
<td>24,790</td>
<td>27,040</td>
</tr>
<tr>
<td>Overturned to Acute</td>
<td>16%</td>
<td>14%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Skilled Level of Care</td>
<td>27%</td>
<td>37%</td>
<td>39%</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Observation Level</td>
<td>30%</td>
<td>27%</td>
<td>27%</td>
<td>32%</td>
<td>38%</td>
</tr>
<tr>
<td>Other Level</td>
<td>6.3%</td>
<td>3.4%</td>
<td>3%</td>
<td>2.9%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Denial Upheld</td>
<td>21%</td>
<td>19%</td>
<td>17%</td>
<td>18%</td>
<td>16%</td>
</tr>
</tbody>
</table>

The point of this data is to show the increasing pressure from insurance companies to deny the inpatient acute level of care payment.

*Threatened Days have more than **doubled** from FY 2008 to FY 2012. CMS does not perform concurrent case review.

Presentation prepared by UPMC Corporate Care Management
Report period: FY'08-FY'12 annualized
### Medical Director Support: Non-Medicare FY’12

<table>
<thead>
<tr>
<th></th>
<th>Discharges</th>
<th>Threatened</th>
<th>Threatened w/ Secondary</th>
<th>Threatened % w/Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>44,138</td>
<td>816</td>
<td>125</td>
<td>15%</td>
</tr>
<tr>
<td>Hospital B</td>
<td>84,357</td>
<td>2,239</td>
<td>154</td>
<td>7%</td>
</tr>
<tr>
<td>Hospital C</td>
<td>47,736</td>
<td>1,188</td>
<td>552</td>
<td>46%</td>
</tr>
<tr>
<td>Hospital D</td>
<td>22,579</td>
<td>163</td>
<td>101</td>
<td>62%</td>
</tr>
<tr>
<td>Hospital E</td>
<td>72,564</td>
<td>1,474</td>
<td>263</td>
<td>18%</td>
</tr>
<tr>
<td>Hospital F</td>
<td>72,570</td>
<td>779</td>
<td>166</td>
<td>21%</td>
</tr>
<tr>
<td>Hospital G</td>
<td>47,977</td>
<td>1,262</td>
<td>52</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>391,921</strong></td>
<td><strong>7,921</strong></td>
<td><strong>1,413</strong></td>
<td><strong>18%</strong></td>
</tr>
</tbody>
</table>

**Opportunity for PA**

- **Peer to peer**
- ** Expedite dc**

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Secondary Reviews by Outcome Non-Medicare

- Expedite dc 19.7%
  - N=666
- Observation 17.6%
  - N=595
- Acute LOC 14.6%
  - N=495
- Blank 15.3%
- Other 14.5%
- Skilled 2.0%
- Recommend Appeal 1.0%
- Separate Admissions 0.4%
- Expedite plan of care 5.7%
- Agree w/ Denial 4.6%
- Bundle Admissions 4.4%

Time frame: FY’12
Time frame: FY’12

Reflects elapsed time between admission date and decision to expedite discharge

Excludes MC FFS

ALOS before an expedite dc decision is 7.5 days

N=666
Physicians A through M are listed with corresponding hours. The chart shows the time in hours it took following an expedite discharge decision for patients to be discharged.

- Physician A: 44 hours
- Physician B: 55 hours
- Physician C: 36 hours
- Physician D: 31 hours
- Physician E: 48 hours
- Physician F: 52 hours
- Physician G: 47 hours
- Physician H: 39 hours
- Physician I: 25 hours

On average, it takes 2 days following an expedite discharge decision for patients to be discharged. Reflects elapsed time between decision to actual discharge. Excludes MC FFS. Time frame: FY’12.
Please note: % ROI calculated based on total cases reviewed in which either skilled, acute, or separate admit was deemed appropriate by the PA
Considerations: (1) ROI may be days not entire admission (2) PA Review outcome at admission level not day by day
Assumptions: (1) Approved skilled/subacute = $1,200/case (2) Approved acute/separate admit = $2,400/case
Data source: Cognos Canopy package

Time frame: FY’12
## % Referrals with Level of Care ROI Non-Medicare

### Time frame: FY’12

<table>
<thead>
<tr>
<th>Medical Director</th>
<th>Count ROI</th>
<th>% ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician A</td>
<td>78</td>
<td>10%</td>
</tr>
<tr>
<td>Physician B</td>
<td>104</td>
<td>17%</td>
</tr>
<tr>
<td>Physician C</td>
<td>56</td>
<td>13%</td>
</tr>
<tr>
<td>Physician D</td>
<td>48</td>
<td>16%</td>
</tr>
<tr>
<td>Physician E</td>
<td>38</td>
<td>23%</td>
</tr>
<tr>
<td>Physician F</td>
<td>3</td>
<td>43%</td>
</tr>
<tr>
<td>Physician G</td>
<td>24</td>
<td>73%</td>
</tr>
<tr>
<td>Physician H</td>
<td>49</td>
<td>26%</td>
</tr>
<tr>
<td>Physician I</td>
<td>10</td>
<td>8%</td>
</tr>
<tr>
<td>Physician J</td>
<td>6</td>
<td>18%</td>
</tr>
<tr>
<td>Physician K</td>
<td>10</td>
<td>13%</td>
</tr>
<tr>
<td>Physician L</td>
<td>52</td>
<td>20%</td>
</tr>
<tr>
<td>Physician M</td>
<td>97</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Please note:** % ROI calculated based on total cases reviewed in which either skilled, acute, or separate admit was deemed appropriate by the PA. 

**Considerations:**
1. ROI may be days not entire admission
2. PA Review outcome at admission level not day by day

**Assumptions:**
1. Approved skilled/subacute = $1,200/case
2. Approved acute/separate admit = $2,400/case

**Data source:** Cognos Canopy package
## Retrospective Inpatient Denials: Top 5 Reasons by Outcome

<table>
<thead>
<tr>
<th>Reason</th>
<th>Total Denials</th>
<th>Overturned</th>
<th>Overturned %</th>
<th>Write-off</th>
<th>Write-off %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Medical Necessity</td>
<td>677</td>
<td>168</td>
<td>25%</td>
<td>319</td>
<td>47%</td>
</tr>
<tr>
<td>Continuation of Care</td>
<td>279</td>
<td>152</td>
<td>54%</td>
<td>70</td>
<td>25%</td>
</tr>
<tr>
<td>Incorrect Level of Care</td>
<td>239</td>
<td>65</td>
<td>27%</td>
<td>93</td>
<td>39%</td>
</tr>
<tr>
<td>Delay in Discharge</td>
<td>172</td>
<td>31</td>
<td>18%</td>
<td>80</td>
<td>47%</td>
</tr>
<tr>
<td>Late Notification</td>
<td>109</td>
<td>54</td>
<td>50%</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>All others</td>
<td>417</td>
<td>169</td>
<td>41%</td>
<td>80</td>
<td>19%</td>
</tr>
</tbody>
</table>

*Top 5 based on count, % of all denials received for specific reason*

*Please note: MA-PA only reflective of Late Pick-up volumes*

**Majority of MN denials are admission denials**

Data source: Access database
FY’12
Excludes MC FFS
## Observation & Extended Recovery: Increase by Payor Group

<table>
<thead>
<tr>
<th>Observation Visits</th>
<th>2011</th>
<th>2012</th>
<th>Variance</th>
<th>% Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor Group A (Managed)</td>
<td>8,904</td>
<td>11,029</td>
<td>2,125</td>
<td>24%</td>
</tr>
<tr>
<td>Payor Group B (Managed)</td>
<td>12,525</td>
<td>14,638</td>
<td>2,113</td>
<td>17%</td>
</tr>
<tr>
<td>Payor Group C (Managed)</td>
<td>11,148</td>
<td>12,731</td>
<td>1,583</td>
<td>14%</td>
</tr>
<tr>
<td>Payor Group D (Managed)</td>
<td>2,568</td>
<td>3,525</td>
<td>957</td>
<td>37%</td>
</tr>
<tr>
<td>Payor Group E (Partially Mgd)</td>
<td>2,443</td>
<td>3,387</td>
<td>944</td>
<td>39%</td>
</tr>
<tr>
<td>Payor Group F (Varies)</td>
<td>3,422</td>
<td>4,307</td>
<td>885</td>
<td>26%</td>
</tr>
<tr>
<td>Payor Group G (Managed)</td>
<td>5,761</td>
<td>6,604</td>
<td>843</td>
<td>15%</td>
</tr>
<tr>
<td>Payor Group H (Non-Mgd)</td>
<td>554</td>
<td>583</td>
<td>29</td>
<td>5%</td>
</tr>
<tr>
<td>Payor Group I (Partially Mgd)</td>
<td>695</td>
<td>473</td>
<td>-222</td>
<td>-32%</td>
</tr>
<tr>
<td>Payor Group J (Non-Mgd)</td>
<td>4,784</td>
<td>4,397</td>
<td>-387</td>
<td>-8%</td>
</tr>
<tr>
<td><strong>Total Pay Group (Finance)</strong></td>
<td>52,804</td>
<td>61,674</td>
<td>8,870</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Conclusion:** The raw increase in observation patients is not driven by one payor grouping. The three highlighted insurance groupings combined make up 66% of the increase.

Data source: Cognos Cube thru June 2012
Excludes Hamot
Observation & Extended Recovery Visits: Top 3 Payors

Top 3 Financial Groups

Data source: Cognos Cube thru June 2012
Excludes Hamot

<table>
<thead>
<tr>
<th>FY'12 % Obs</th>
<th>Medicare Mgd</th>
<th>Blue Cross Mgd</th>
<th>Medicaid Mgd</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.9%</td>
<td>29.3%</td>
<td>30.1%</td>
<td></td>
</tr>
</tbody>
</table>

Axis Title

- Medicare Managed
- Blue Cross Managed
- Medicaid Managed
### Medical Observation Visits: Targeted Dx Variance

<table>
<thead>
<tr>
<th></th>
<th>FY'11</th>
<th>FY'12</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>8,905</td>
<td>10,136</td>
<td>1,231</td>
<td>14%</td>
</tr>
<tr>
<td>Abd pain</td>
<td>2,157</td>
<td>2,324</td>
<td>167</td>
<td>8%</td>
</tr>
<tr>
<td>Syncope/Collapse</td>
<td>1,287</td>
<td>1,410</td>
<td>123</td>
<td>10%</td>
</tr>
</tbody>
</table>

The significant increase in medical observation visits is driven by three symptom based diagnoses. 1-day inpatient admissions for these diagnoses are being targeted by Managed Care Payors and Third Party Auditors, especially RAC and MAC.

Data source: Cognos Cube thru June 2012
Excludes Hamot
Executive Summary: Audit Volume

FY'10 only 5 months of data
## High-level Audit Analysis

### Denial Dollar Outcomes

<table>
<thead>
<tr>
<th>Denial Dollar Outcomes</th>
<th>FY'10</th>
<th>FY'11</th>
<th>FY'12</th>
<th>Variance from Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upheld</td>
<td>$977,258</td>
<td>$3,475,253</td>
<td>$3,640,075</td>
<td>$716,878</td>
</tr>
<tr>
<td>Overturned</td>
<td>$966,777</td>
<td>$2,732,848</td>
<td>$2,732,848</td>
<td>$742,071</td>
</tr>
</tbody>
</table>

*As of June 30, 2012 data will change

Time frame: FY’12

### Summary of Audit Analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>FY'10 (Partial year)</th>
<th>FY'11</th>
<th>FY'12</th>
<th>Grand Total</th>
<th>Variance from Prior</th>
<th>% Variance from Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Audited Accounts</td>
<td>Total cases where there is a Third Party Audit request is present</td>
<td>3,175</td>
<td>12,901</td>
<td>18,840</td>
<td>34,914</td>
<td>5,938</td>
<td>46%</td>
</tr>
<tr>
<td>Total Audit Dollars (Final payment amount)</td>
<td>Total dollars associated with Third party Audit requests</td>
<td>$29,809,924</td>
<td>$128,104,181</td>
<td>$161,846,395</td>
<td>$319,761,900</td>
<td>$33,744,214</td>
<td>26%</td>
</tr>
<tr>
<td>Total Audit Chart Requests</td>
<td>Total cases where there is a chart request is present</td>
<td>3,168</td>
<td>12,635</td>
<td>16,232</td>
<td>34,035</td>
<td>5,597</td>
<td>44%</td>
</tr>
<tr>
<td>Total Audit Chart Request Dollars</td>
<td>Total dollars associated with chart requests</td>
<td>$29,808,767</td>
<td>$128,843,520</td>
<td>$158,613,920</td>
<td>$315,265,417</td>
<td>$31,769,700</td>
<td>25%</td>
</tr>
<tr>
<td>Open Chart Requests</td>
<td>Total cases where the chart request is still open</td>
<td>0</td>
<td>1</td>
<td>7,149</td>
<td>7,150</td>
<td>7,148</td>
<td></td>
</tr>
<tr>
<td>Open Chart Request Dollars</td>
<td>Total dollars associated with open chart requests</td>
<td>$0</td>
<td>$1,529</td>
<td>$66,998,677</td>
<td>$66,998,216</td>
<td>$66,997,140</td>
<td></td>
</tr>
<tr>
<td>AuditApprovals</td>
<td>Total cases where there is a Third Party Audit request present AND Payment Agrees</td>
<td>2,716</td>
<td>10,697</td>
<td>7,367</td>
<td>21,280</td>
<td>(2,830)</td>
<td>-25%</td>
</tr>
<tr>
<td>Audit Denials</td>
<td>Total cases where there is a Third Party Audit request present AND Payment Disagrees</td>
<td>428</td>
<td>1,833</td>
<td>3,147</td>
<td>5,408</td>
<td>1,314</td>
<td>72%</td>
</tr>
<tr>
<td>Audit Denial Dollars</td>
<td>Total dollars associated with audit denials</td>
<td>$2,541,813</td>
<td>$12,147,076</td>
<td>$15,503,381</td>
<td>$30,592,220</td>
<td>$3,655,255</td>
<td>30%</td>
</tr>
<tr>
<td>Open Denials</td>
<td></td>
<td>125</td>
<td>478</td>
<td>2,206</td>
<td>2,612</td>
<td>1,728</td>
<td></td>
</tr>
<tr>
<td>Open Denial Dollars</td>
<td></td>
<td>$572,309</td>
<td>$3,140,431</td>
<td>$9,875,476</td>
<td>$13,691,216</td>
<td>$6,738,045</td>
<td></td>
</tr>
<tr>
<td>Denials with Outcome: Lost/Upheld</td>
<td></td>
<td>165</td>
<td>970</td>
<td>315</td>
<td>1,953</td>
<td>(155)</td>
<td>-16%</td>
</tr>
<tr>
<td>Denial $ with Outcome: Lost/Upheld</td>
<td></td>
<td>$977,258</td>
<td>$4,449,589</td>
<td>$3,640,075</td>
<td>$9,066,922</td>
<td>($809,514)</td>
<td>-15%</td>
</tr>
<tr>
<td>Denials with Outcome: Won/Overturned</td>
<td></td>
<td>125</td>
<td>439</td>
<td>433</td>
<td>1,057</td>
<td>(56)</td>
<td>-13%</td>
</tr>
<tr>
<td>Denial $ with Outcome: Won/Overturned</td>
<td></td>
<td>$956,777</td>
<td>$3,475,253</td>
<td>$2,732,848</td>
<td>$7,164,878</td>
<td>($742,405)</td>
<td>-21%</td>
</tr>
</tbody>
</table>
Audit Dollars by Auditor

Total Audit $ by Auditor

For low volume auditors: 'Other' category shows auditors who have audits Previous FY + Current FY below 500

Time frame: FY’12
## Audited Medical Director Referrals

### Table: Referrals Audited

<table>
<thead>
<tr>
<th>PA Referrals</th>
<th>Referrals Audited</th>
<th>% Audited</th>
<th>Referrals Denied</th>
<th>% Denied</th>
<th>Open Denials</th>
<th>Appealed Won</th>
<th>Appealed Lost</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,041</td>
<td>292</td>
<td>2.91%</td>
<td>147</td>
<td>1.46%</td>
<td>107</td>
<td>13</td>
<td>2</td>
<td>25</td>
</tr>
</tbody>
</table>

### Top 5 DRGs Audited

<table>
<thead>
<tr>
<th>Code</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>313</td>
<td>83</td>
</tr>
<tr>
<td>392</td>
<td>21</td>
</tr>
<tr>
<td>552</td>
<td>13</td>
</tr>
<tr>
<td>191</td>
<td>6</td>
</tr>
<tr>
<td>244</td>
<td>6</td>
</tr>
</tbody>
</table>

### Top 5 DRGs Denied

<table>
<thead>
<tr>
<th>Code</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>313</td>
<td>81</td>
</tr>
<tr>
<td>392</td>
<td>19</td>
</tr>
<tr>
<td>552</td>
<td>8</td>
</tr>
<tr>
<td>191</td>
<td>5</td>
</tr>
<tr>
<td>190</td>
<td>4</td>
</tr>
</tbody>
</table>

Data Source: Cognos Canopy & Audit+ Packages  
As of March 31, 2012
Are you making the right decision?

Determination
- Admit
- Not Admit

Request
- Peer to Peer
- Results letter
- Overpayment?

Denial
- Rejection
- Retraction

Appeal
- Appeal
- No appeal

Closure
- Won
- Lost
- Underpayment

Does your documentation support your decision?

Can you support your argument? Will your documentation hold up?

Does the cost outweigh the benefit?

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Development of clinical protocols

- Symptom based diagnosis
  - Chest pain
  - Abdominal pain
  - Syncope/collapse
- Short length of stay (expected < 23 hours)
- Utilization of ancillary testing
- Observation determination after 2ndry review
How to measure Success?

- Increase Revenue
  - Secondary Review: Support Level of Care
  - Concurrent Denials: Payer Interactions
- Decrease Cost of Care
  - Secondary Review: Expedite Discharge Planning
  - Track and act on Avoidable Delays
  - Complex Case Management: Get a plan
    - Family Conference, Set Expectations, Clear Communication
- Support Patient-Centered Care
  - Pathways Development and Implementation
  - Reduce Readmissions – Targeted Quality Projects
Learning Lessons

- There will never be enough Medical Director Support
- Document your successes/opportunities
- Outsourcing work has pros/cons
- Identify opportunities for improvement
- Finance is never satisfied!
Take “aways”

• Your decision has downstream impact
  – Value Based Purchasing
  – Readmissions
  – Audits
• Don’t underestimate RISK
• Collaboration is key
• Don’t solve each issue separately
• Learn from your past
• PREVENT future risk!
Find the SWEET SPOT!

Quality of Care

Healthcare Reform

Financial Performance
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Vice President, Accountable Care
UPMC Provider Services
redmanca@upmc.edu

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