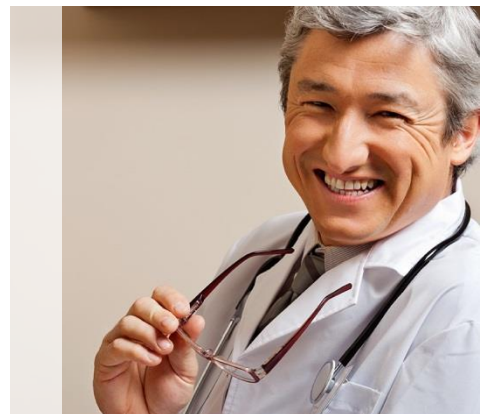


Medicare Dis-Advantage Mis-Managed Medicaid

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What is the Regulation?

MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

What's your Case Manager's Reality?

- Demand patients stay observation for days on end
- Rarely approve LTACH, acute rehab or even SNF
- 48-72-96 hrs to get approval for post-acute care
- Contracted home care agency has bad reputation
- DME supplier will not deliver supplies in a timely manner
- Bundling all readmissions within 30 days

It's all in the Contract

What criteria are used?

UHC Policy Number: H-006

Coverage Statement: Hospital services (inpatient and outpatient) are covered when Medicare criteria are met.

For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Cigna Obs Policy 0411

In general, the duration of observation care services does not exceed 24 hours, although in some circumstances, individuals may require a second day. Observation care for greater than 48 hours without inpatient admission is generally considered not medically necessary and may be subject to medical review.

One RAC Relief User Issue

Sending appeals and then following up to check the status only to learn they don't have any record of us filing an appeal and we will need to resend it to them.

Suggested Response: Would you like me to contact the Office of Civil Rights and file the HIPAA breach report for you since you lost PHI that I can prove was in your possession?

See article- Lost Records? HIPAA at
www.ronaldhirsch.com

Aetna Precertification List

Observation stays greater than 24 hours will require precertification. Observation stays greater than 24 hours are considered an inpatient stay and are subject to all inpatient policies, including the timely notification requirement.

What about Criteria?

-
- Apply criteria on Episode day 2 of the appropriate subset

NOTE: CMS requirements for “hospital based services” can be determined by applying criteria at the Observation, Acute, Intermediate, or Critical level of care. Patients who meet Observation criteria by demonstrating that they require hospital based services will satisfy CMS’s requirement for inpatient status.

For example: A patient meeting partial responder criteria at the Observation level of care on episode day 2 would be considered an inpatient once they have crossed the second midnight of care.

- For complications of an ambulatory surgery or procedure, apply criteria on Post-op day 1 in the General Surgical subset

Inpatient admission required rather than observation care because of 1 or more of the following:

Significant finding or clinical condition judged too severe (eg, treatment intensity or expected duration requires inpatient admission) **or too persistent (eg, insufficient improvement or worsening despite initial intervention or treatment for up to 24 hours)** to be within scope of observation care, including 1 or more of the following:

Vomiting that is severe or persistent

Severe electrolyte abnormalities requiring inpatient care

Hemodynamic instability that is severe or persistent

Acute renal failure

Other significant finding or clinical condition judged not to be within scope of observation care

Treatment or monitoring requiring inpatient admission (eg, due to intensity or expected duration) as indicated by need for 1 or more of the following(6)(7)(8):

Continued inpatient IV hydration due to failure of rehydration treatment (eg, for greater than 24 hours) and expected improvement with further inpatient evaluation and treatment

Being Unready for discharge = Admit

Rapid Review Guidelines



Hospitalization

[Return to top of Heart Failure: Rapid Review - ISC](#)

Goal Length of Stay: Ambulatory or 2 days

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Discharge Readiness

[Return to top of Heart Failure: Rapid Review - ISC](#)

- Discharge readiness is indicated by patient meeting Recovery Milestones including **ALL** of the following(1)(12)(67)(68)(69)(70):
 - Ambulatory or appropriate activity level for age and condition
 - Oral hydration, medications, and diet
 - MI excluded
 - Hemodynamic stability
 - Tachypnea absent
 - Oxygenation at baseline or discharge oxygen regimen ordered
 - Cardiac rate and rhythm normal or documented appropriate for patient and discharge plan
 - Pulmonary edema resolved
 - Volume status acceptable on oral medication
 - Discharge plans and education understood

Readmissions- CMS Policy

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim. Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

Aetna Readmission Policy

Effective July 1, 2015, we're changing our readmissions policy. To match our readmissions policy for Aetna Medicare members, we're also extending the review timeframe for readmissions from 2 days to 30 days for our Aetna commercial members. This policy will apply to agreements that include a diagnosis-related group (DRG) methodology for inpatient stays.

Regence

Hospital readmission review (group and Individual plans)

All hospital readmissions for the same, similar or related condition which occur within 48 hours of the original discharge from hospital/facility or as defined in the Hospital Provider Contract is considered a continuation of initial treatment.

The two hospital stays will be consolidated into one, combining all necessary codes, billed charges and the length of stay. The maximum allowable for Covered Services will be recalculated per the reimbursement terms of the hospital/facility contract so that reimbursement is for a single, per case reimbursement.

UHC

A LVN, LPN or RN will review the medical records and supporting documentation provided by the facility to determine whether the two admissions are related.

If the subsequent admission is related to the initial admission and appears to have been preventable, the LVN, LPN or RN will submit the case to a medical director, who is a physician, for further review.

The medical director will review the medical records to determine if the subsequent admission was preventable and/or there is an indication that the facility was attempting to circumvent the PPS system.

Anthem

Anthem Medicare Advantage considers a readmission to the same hospital for the same, similar, or related condition on the same date of service to be a continuation of initial treatment. Anthem Medicare Advantage defines same day as services rendered within a 24-hour period (from time of discharge to time of readmission) for participating providers.

Anthem Medicare Advantage will utilize clinical criteria and licensed clinical medical review for readmissions from day 2 to day 30 in order to determine if the second admission is for:

- 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

That's the mess, now what are the solutions?