

The Other Side of Cellulitis: The Very Basics of Medicare and Medicaid for the Hospitalist

Learning Objectives-

Understand the meanings of the following terms:

- ✓ CMS = Centers for Medicare and Medicaid Services
 - ✓ DRG = Diagnosis Related Group
 - ✓ MDC = Major Diagnostic Category
 - ✓ ICD-9-CM = International classification of diseases, ninth revision, clinical modification
 - ✓ IPPS = Inpatient Prospective Payment System
 - ✓ IM = Important Notice
 - ✓ DN = Denial Notification
 - ✓ QIO = Quality Improvement Organization
 - ✓ Medicare
 - ✓ Medicaid
 - ✓ P4P = Pay For Performance
 - ✓ DSHS = Department of Social Health Services
 - ✓ DHHS = Department of Health and Human Services
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Question #1:

You are starting as a new hospitalist at an established community hospitalist program. You admit a 67 year old homeless woman for a right lower extremity cellulitis. You treat her with IV antibiotics, and transition her to oral antibiotics as the leg seems to improve. By hospital day 4 she is still having right lower extremity pain (you have ruled out DVT and fracture with the appropriate studies). Her WBC count is normal, and she is afebrile. By hospital day 5, she is still having leg pain, and is unable to walk without crutches. She refuses placement at a respite bed or a SNF. On hospital day 6, you are about to round on her when you get a page from the hospital's utilization review team. They say, "This is a Medicare patient, and based on her likely DRG, the hospital is losing money every day. Were you ever planning on discharging her?"

- What does DRG stand for?
 - A. Drug resistant gram-positive
 - B. Drug resistant gram-negative
 - C. Diagnosis resistant group
 - D. Diagnosis related group
 - E. Diagnosis related gram-positive
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To understand what a DRG is, you need to understand what Medicare is, and how hospitals get reimbursed for Medicare patients.

What is Medicare?

- Medicare is the federal health insurance program for all Americans older than 65 years old, all Americans with end stage renal disease, and certain Americans younger than 65 years old with disabilities.
- Medicare has 4 parts:
 - Part A: Mainly hospital insurance, also SNF, hospice, home health
 - Part B: Outpatient care, some preventative care
 - Part C: Combines parts A and B, and sometimes D, but is managed by a Medicare approved private insurance
 - Part D: Prescription drug coverage, run by private companies approved by Medicare

Why is Medicare important?

- Most Americans over 65 years old are covered by Medicare part A.
- This means that a huge number of hospitalized patients have Medicare coverage – and hospitals are very dependent on Medicare reimbursements.

Medicare reimbursements to hospitals are the responsibility of CMS and IPPS

- Medicare reimbursements underwent a major overhaul in 1983 when the Inpatient Prospective Payment Program (IPSS) was started.
- This was a change from pay for service to payment based on how much it should cost to care of the average patient with a given condition.
- The goal was to encourage hospital efficiency and to simplify reimbursement.
- The Inpatient Prospective Payment Program is the system by which the CMS (Center for Medicare and Medicaid Services) pays hospitals for taking care of Medicare patients.

What is an ICD-9-CM?

- The smallest unit of information used to categorize a Medicare (or any patient) is the ICD-9-CM code.
- There are over 10,000 ICD-9-CM codes = the International classification of diseases, ninth revision, clinical modification.
- This was originally designed as a classification system for diseases, but is now also used with reimbursement.
- The ICD-9 code for cellulitis of lower extremity, excluding the foot, is 682.6.

What is an MDC?

- The ICD-9-CM codes are grouped into 25 major diagnostic categories (MDC's).
- Cellulitis fits into MDC 9 – Diseases of the Skin, Subcutaneous Tissue and Breast.

What is a DRG?

- The MDC's are then broken down into DRG's – diagnosis related groups.
- The purpose of a diagnosis related group is to classify a diagnosis into a group where patients demonstrate similar resource consumption and length of stay patterns.
- The DRG number for cellulitis, age greater than 17, without complications, is 279.

How does a DRG number determine the amount of reimbursement?

- A hospital bill includes charges for **physician services** and **hospital services**.
 - Physician services charges are based on our documentation (CPT, E/M coding, etc – not covered here).
 - Hospital services charges are also dependent on our documentation.
 - The DRG can be generated by “ grouper ” software, where diagnoses, patient age, etc are entered and a DRG number comes out.
 - The DRG alone does not generate the amount of reimbursement.
 - The DRG is given a relative weight (the actual value of the DRG) – this is balance between a fair compensation, the government’s desire to minimize costs, and the need for hospitals to stay in business.
 - The relative weight is then influenced by the hospital base rate (determined by the type of hospital, type of services provided, and hospital location).
 - The CMS determines the relative weight and hospital base rate from years of data on the hospitalizations of Medicare patients at hundreds of hospitals.
 - The average length of stay for DRG 279 is 3 days.
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Question #2:

You decide that your patient is ready to discharge after all. You tell her that you are discharging her later that day. But she tells you that she remembers hearing something about how she has to have two days warning, and that she is about to call her lawyer.

- Which of the following is true?
 - A. All Medicare patients can appeal their discharge if they don’t feel ready to leave
 - B. Some Medicare patients can appeal their discharge if they don’t feel ready to leave
 - C. All hospital patients can appeal their discharge to Medicare if they don’t feel ready to leave
 - D. Some hospital patients can appeal their discharge to Medicare if they don’t feel ready to leave
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What has changed in the way that hospitals are required to notify Medicare patient’s of their hospital discharge appeal rights?

- The objective is to avoid inappropriate discharges, (which ironically may have been instigated by the inpatient prospective payment system in the first place)
- November 27, 2006: CMS published **final regulations that established revised requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights**
- July 1, 2007: New notice requirements went into effect

What is the hospital required to do?

- Issue the IM (important message - this is the official Medicare abbreviation) within 2 days of admission, and obtain the signature of the beneficiary or his or her representative
- Deliver a copy of the signed notice **at least 4 hours prior to discharge, but no more than 2 days before the discharge.**
- For beneficiaries who request an appeal, the hospital will deliver a more detailed notice.

What can the patient do?

- At any point up until the moment of discharge, the patient can appeal the discharge
- The patient has to directly contact the local QIO (Quality improvement organization, an independent reviewer hired by Medicare, should be available 24 hours a day, 7 days a week) and ask for an “expedited review”

What is the next step after the patient appeals to the QIO?

- The DN (Detailed Notice) has to be given to the patient as soon as possible, but no later than the noon following the day of appeal
 - All pertinent information will be provided to the QIO by the hospital, and the patient will speak with the QIO
 - The QIO will make a decision within 1 day of receiving all the pertinent information
 - Medicare will not cover any services after the noon of the following day after notification of the decision (or keep covering if the appeal is accepted).
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Question #3:

You realize that you’re in over your head, and decide to go talk to your medical social worker. He looks up the patient and says, “What are you talking about? She isn’t a Medicare patient, she is a Medicaid patient.”

- Which of the following is true?
 - A. A Medicaid patient cannot also be a Medicare patient
 - B. A Medicaid patient can also be a Medicare patient
 - C. All Medicaid patients are also Medicare patients, but all Medicare patients are not necessarily Medicaid patients
 - D. All Medicare patients are also Medicaid patients, but all Medicaid patients are not necessarily Medicare patients
 - E. Medicare and Medicaid refer to different parts of the same program, and can in some cases be used interchangeably
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What is Medicaid?

- Jointly funded and administered by federal and state government
- Medical and health related services coverage for low-income people
- Federal law establishes the framework, but Medicaid is different in every state
- States customize the program and manage operations
- Some people are federally required to be covered
- Medicaid is the second largest part of States’ budgets

Medicaid in Washington State

- DSHS = Department of Health and Social Services = Washington State's agency to use Medicaid funds
 - Medicaid funds about 75% of DSHS programs, and funds at least part of every program
 - Provides full or partial health care coverage for about 16 percent of Washington residents (around 1 million people)
 - Covers about 16 percent of U.S. residents (44 million)
 - In Washington State 12% of Medicaid enrollees also have Medicare
 - Washington Medicaid Study. Report 04-4. January 7, 2004, JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE
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Question #4:

It turns out that your patient has both Medicare and Medicaid coverage. You confirm with the nursing staff that she has received the IM. You are able to collaborate with her on a plan for discharge to a respite bed the next day. When you round on her the following morning, you find that your patient had spiked to 39.1 F overnight, with flank pain and dysuria. The nocturnalist had sent a UA, which had 4+ WBC, and started IV antibiotics. You are trying to remember why your patient had a foley catheter for the past week when your pager goes off. The hospital utilization review team wants to chat with you.

- Which of the following is true?
 - A. The patient has to be discharged because Medicare will not pay for a problem not related to the reason for admission
 - B. The patient has to be “discharged” and “readmitted” because otherwise Medicare will not reimburse for the new hospital acquired condition
 - C. The hospital can now bill at a higher DRG, since “pyelonephritis” gets more reimbursement than “cellulitis”
 - D. None of the above
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What does pay for performance (P4P) mean for hospitalists?

- In general, these are initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive their health care services
- Currently, P4P as it related to Medicare patients is mainly an incentive for reporting data: “a hospital that does not submit performance data for the ten quality measures will receive a 0.4 % point reduction in its annual payment update from CMS for FY 2005, 2006 and 2007”
- The Hospital Quality Initiative requires hospitals to report on quality measures - <http://www.hospitalcompare.hhs.gov/>
- According to CMS, this is “a website/web tool developed to publicly report valid, credible and user-friendly information about the quality of care delivered in the nation's hospitals”

Pneumonia Process of Care Measures Higher Percentages Are Better (some of the recommended care given to patients if appropriate*)			
Process of Care Measure	PERCENTAGE FOR HARBORVIEW MEDICAL CENTER	PERCENTAGE FOR UNIVERSITY OF WASHINGTON MEDICAL CTR	PERCENTAGE FOR VIRGINIA MASON MEDICAL CENTER
Percent of Pneumonia Patients Assessed and Given Influenza Vaccination if appropriate*	21% of 24 patients ^{1,2}	33% of 30 patients	74% of 78 patients
Percent of Pneumonia Patients Given Initial Antibiotic(s) within 4 Hours After Arrival if appropriate*	75% of 160 patients ²	51% of 153 patients	81% of 212 patients ²
Percent of Pneumonia Patients Given Smoking Cessation Advice/Counseling if appropriate*	68% of 112 patients ²	100% of 44 patients	98% of 58 patients ²

What other incentives for quality are in development?

- Premier Hospital Quality Incentive Demonstration
- Hospitals will receive bonuses based on their performance on quality measures selected for inpatients with specific clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements.
- All of the hospitals in the top 50% will be reported as top performers
- Hospitals in the top 20% will be recognized and given a financial bonus

How is the CMS trying to encourage hospitals to minimize complications during the hospital stay?

- Congress passed a bill requiring CMS to select, by October 1, 2007, at least two conditions that are:
 - High cost or high volume or both
 - Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and
 - Could reasonably have been prevented through the application of evidence-based guidelines.

- For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission.
 - Object left in surgery
 - Blood incompatibility
 - Air embolism
 - Falls
 - Mediastinitis
 - Catheter associated urinary tract infections
 - Pressure ulcers
 - Vascular catheter associated infections
- Coming soon thereafter:
 - Ventilator associated pneumonia
 - “Septicemia”
 - Deep vein thrombosis
- Also considered:
 - C diff colitis

References:

1. **Federal Register** / Vol. 71, No. 227 / Monday, November 27, 2006 / Rules and Regulations
2. Centers for Medicare and Medicaid Services (CMS), Medicaid Statistical Information System (MSIS) report.
3. <http://www.hospitalcompare.hhs.gov/>
4. Washington Medicaid Study. Report 04-4. January 7, 2004, JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE