OASIS Alert

Industry Notes

Study Shows Home Care Saves Money On Rehospitalizations

A Medicaid transitional care program that includes home visits has reduced hospital readmissions by 20 percent, according to a study published in the Health Affairs journal. Could your hospital readmission quality measures benefit from something similar?

"In 2008 North Carolina initiated a state-wide population-based transitional care initiative to prevent recurrent hospitalizations among high-risk Medicaid recipients with complex chronic medical conditions," says the study abstract. "In a study of patients hospitalized during 2010–11, we found that those who received transitional care were 20-percent less likely to experience a readmission during the subsequent year, compared to clinically similar patients who received usual care."

In the program, care managers typically talked to high-risk patients in the hospital and followed up with a home visit within 72 hours after discharge, the Raleigh News & Observer newspaper reports. At the patient's home, the care manager reviewed the patient's prescriptions with the patient and family and made sure the patient kept doctor's appointments. "In some cases, the manager arranged transportation, even accompanying the patient to the doctor's office," the newspaper notes.

"In the absence of this kind of support, the majority of these highest-risk patients will be rehospitalized within three months," said the study's lead author, **C. Annette DuBard** with **Community Care of North Carolina**. "We can be confident this is a positive return on investment because so many readmissions were averted."

The study abstract is at http://content.healthaffairs.org/content/32/8/1407.

Avoid These Record Correction Pitfalls, MAC Warns

Are you committing some of the major record correction no-nos that HHH Medicare Administrative Contractor **CGS** often sees?

"The CGS Medical Review department frequently sees changes in medical record documentation that do not follow the record keeping principles" Medicare sets out in its Medicare Program Integrity Manual, the MAC says in its September newsletter for providers.

The most common inappropriate practices include entries that are scribbled over or blackened out; crossed through with only initials annotating the change; added with only initials or only a date, annotating the change; crossed through with no notations; and written over, CGS reports.

Resources: See CMS's correction guidelines in the MAC's article at www.cgsmedicare.com/hhh/pubs/mb_hhh/2013/09_2013/index.html#011.

Medicare Reviews Less Than 1% Of Claims

It may seem like you are bombarded with record requests for medical review, but the Medicare program is still reviewing a tiny portion of the claims it pays.

The **Centers for Medicare & Medicaid Service**s has four contractors that conduct claims review Medicare Administrative Contractors (MACs), Zone Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and the Comprehensive Error Rate Testing (CERT) contractor, the **Government Accountability Office** says in a new report. "Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency."

"Compared to over 1 billion claims processed in 2012, all four types of contractors combined reviewed less than one 1 percent of claims, about 1.4 million reviews, for which providers might be contacted to send in medical records or other documentation," the GAO says in a summary of the report.

Differences in review requirements for the four types of contractors "may impede efficiency and effectiveness of claims reviews by increasing administrative burden for providers," the GAO says in a summary of its report. "There are differences in oversight of claims selection, time frames for providers to send in documentation, communications to providers about the reviews, reviewer staffing, and processes to ensure the quality of claims reviews."

For example: "While the CERT contractor must give a provider 75 days to respond to a request for documentation ... the ZPIC is only required to give the provider 30 days," the GAO notes.

Bottom line: "Having inefficient processes that complicate compliance can reduce effectiveness of claims reviews," GAO says.

The **Department of Health and Human Services** already is looking at standardizing the minimum number of days providers have to respond to ADRs, HHS Assistant Secretary for Legislation **Jim Esquea** says in the Department's response to the report. Standardizing that number "could help minimize provider confusion," Esquea allows.

HHS will take steps to reduce differences in medical review elsewhere as well, the agency pledges.

Resource: A link to the report is at www.gao.gov/products/GAO-13-522.