

INSPECTION OF
INAPPROPRIATE DISCHARGES
AND
TRANSFERS

RICHARD P. KUSSEROW
INSPECTOR GENERAL

Inspection Prepared By:

Lead Region:

William Moran
Natalie Coen
Kitty Ahern
Donald Kuhl
Margaret Shell
John Traczyk
Joe Penkrot
Terry Quirk

With Assistance By:

Headquarters:

David Hsia, M.D.
Barton McCann, M.D.
Barry Steeley

Regions:

Lucille Cop - II
Renee Schlesinger - II
Bill Young - III
Kathy Admire - IX
Paul Gottlober - IX

Office of Analysis & Inspections
Region V
300 So. Wacker Drive
26th Floor
Chicago, IL 60606

March, 1986

OAI# P-05-86-00050

MAJOR FINDINGS

- o Based on the findings of this inspection, it is apparent that occurrences of premature discharges and inappropriate transfers do exist and must continue to be addressed aggressively by the Health Care Financing Administration (HCFA) and the Peer Review Organizations (PROs).
- o During 10/1/83 - 5/31/85, HCFA reported 4,724 cases of premature discharges and inappropriate transfers. Yet, only 2,688 (57%) of the reported cases could actually be found. This is due to the phasing out of the Medical Review Entities (MREs), inconsistent instructions given by HCFA, and inaccurate reporting by the PROs. Another 1,018 cases were reviewed, of which 282 were reported after 5/31/85 and 736 had never been reported (See chart on page 9.) Also, during the time frames mentioned above, 14 (30%) of the PROs were not reporting premature discharges or inappropriate transfers. Therefore, the overall extent of the problem is still not fully known.
- o Of the 3,706 cases reviewed, 3,336 (90%) were referred by the PROs; 370 (10%) were referred prior to PRO implementation. One hundred and fifty-seven (4%) of the 3,706 cases were not inappropriate discharges or transfers. Of the remaining 3,549 cases, 2,907 (82%) were premature discharges, 491 (14%) were inappropriate transfers, and 151 (4%) could not be categorized by type.
- o Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 2,146 (60%) of the 3,549 cases. PRO disposition of these cases ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 927 (43%) of the cases with identified quality issues the only apparent action taken by the PRO was referral to HCFA.
- o Of the cases reviewed, medical records involving 133 patients were referred to OIG physician consultants for review. Nineteen were classified by OIG consultants as exhibiting gross and flagrant instances of substandard care. PROs took no corrective action, other than referral to HCFA, on 12 of these 19 cases. In the opinion of the OIG medical consultants, inappropriate actions were taken on 106 of the 133 cases. Thirty-eight of these cases have been returned directly to the PROs for various recommended

actions. The remaining cases are currently being reviewed by HCFA.

- o PROs did have the authority to take action on the quality issues identified in this study. It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges and inappropriate transfers.
- o During OIG site visits conducted in September and December, 1985, problems were noted with the PRO's accumulation of data pertaining to the quality of care rendered by physicians and hospitals. This data is necessary for the identification of abusive patterns and subsequent corrective action.
- o HCFA has reviewed the recommendations contained in this report and concurs. It has already begun to correct a number of problems identified in the inspection. Details regarding HCFA's actions can be found in the appendix attached to this report. Also, increased sanction activity by the PROs against physicians/providers demonstrating abusive patterns of practice has been recently noted.

TABLE OF CONTENTS

	PAGE
I. PURPOSE AND METHODOLOGY	1
II. OVERVIEW	3
III. CASE RECONCILIATION	7
IV. CATEGORIZING CASES AND DOCUMENTING DISPOSITIONS	10
V. MECHANISMS TO ADDRESS CASES OF PREMATURE DISCHARGE AND INAPPROPRIATE TRANSFER	20
VI. RECOMMENDATIONS	26
VII. APPENDIX	28

I. Purpose and Methodology

At the request of the Inspector General, a national program inspection was conducted of identified instances of premature discharges and inappropriate transfers occurring under Medicare's Prospective Payment System (PPS).

The objectives of this inspection were to:

- 1) Determine the number of premature discharges and inappropriate transfers referred to the Health Care Financing Administration (HCFA) by medical review entities (MREs), fiscal intermediaries (FIs), and Peer Review Organizations (PROs) from 10/1/83 through 5/31/85;
- 2) Categorize the cases and document their disposition;
- 3) Review the appropriateness of corrective action on cases where the PRO, MRE or FI, through its review process, identified potentially gross and flagrant or substantive instances of substandard care; and
- 4) Examine the procedures and instructions pertaining to the identification and disposition of these cases.

This inspection was not meant to determine the overall effect of PPS on quality of care rendered to Medicare beneficiaries nor was it designed to determine the frequency of inappropriate discharges and transfers occurring within the PPS system. It focused only on instances of inappropriate discharges and transfers as they were identified by the PROs through review mechanisms extant at the time. The broader issue of quality of care will be more fully addressed in other reports, particularly those to be issued by the Inspector General, HCFA, and the Assistant Secretary for Planning and Evaluation (ASPE).

According to HCFA, 4,724 cases of premature discharges and inappropriate transfers were referred to the HCFA regional offices between 10/1/83 and 5/31/85 by various medical review entities, including 33 of the 47 PROs located in non-waiver PPS states. The actual referrals were kept in the HCFA regional offices, excluding the New York region where all states are exempt from PPS. Office of Inspector General (OIG) teams went to the nine remaining HCFA regions to gather identifying information on the referral cases. During September and December, 1985, onsite visits were also conducted at 19 of the 33 PROs to record what actions were taken by them on cases with identified quality of care issues. The remaining 14 PROs who had

referred to HCFA minimal numbers of cases were contacted by the HCFA Project Officers to ascertain the disposition of those cases. In all instances, the data gathered was what was documented in the PRO's case file. If corrective action was taken on cases but not documented in the material available to the reviewer, it was not recorded.

Discussions focusing on premature discharges and inappropriate transfers and HCFA instructions regarding these cases were conducted with HCFA's Central Office, the nine regional offices, all 47 PROs, and 15 state hospital associations. National associations such as the American Medical Association (AMA), American Hospital Association (AHA), American Peer Review Association (AMPRA), and American Association of Retired Persons (AARP) were also contacted.

II. Overview

In March, 1983, Congress passed legislation requiring a new system for reimbursing Medicare inpatient hospital stays. Implementation of the Prospective Payment System began on October 1, 1983, and by October 1, 1984, all non-exempt hospitals servicing Medicare inpatients were being paid based on 468 diagnostic related groups (DRGs). DRGs categorize patient stays based on principal and secondary diagnoses and surgical procedures.

Consistent with the new era of competition and sound financial practices pervading the private sector of health care, Congress built into Medicare's Prospective Payment System economic incentives to curb escalating costs and prevent overutilization of inpatient stays. PPS encourages the use of outpatient facilities. It rewards hospitals that provide efficient care by allowing them to keep the dollar differences between their actual operating costs and Medicare's DRG payment.

While the intent of Congress was to reduce health care costs, it was also concerned that the quality of health care not suffer under this new system. To ensure the integrity of PPS and to maintain the high quality of care afforded patients under the cost reimbursement system, Congress established and provided funding for Peer Review Organizations. The 54 PROs under contract with HCFA are located in each state, territory, and the District of Columbia. (Forty-seven PROs operate in non-waiver PPS states.) They are responsible for determining:

- 1) whether the services provided or proposed are reasonable and medically necessary for the diagnosis and treatment of illness or injury ...;
- 2) whether services ... could ... be effectively furnished on an outpatient basis ...;
- 3) the medical necessity, reasonableness, and the appropriateness of hospital admissions and discharges;
- 4) ...appropriateness of inpatient hospital care for which additional payment is sought under outlier provisions;

- 5) whether a hospital has misrepresented admission or discharge information or has taken an action that results in unnecessary admission ... unnecessary multiple admissions ... or other inappropriate medical or other practices ...;
- 6) the validity of diagnostic and procedural information supplied by the provider;
- 7) the completeness, adequacy, and quality of hospital care provided; and
- 8) whether the quality of services meets professionally recognized standards of health care.

(Peer Review Organization Manual, IM 2001.1)

To assist the PROs in carrying out their responsibilities, Congress gave them authority to deny payment for inappropriate services, to take corrective actions as necessary and to sanction physicians and hospitals providing poor quality care, or attempting to circumvent the new system.

Between October, 1983, and October, 1984, MREs and FIs were responsible for handling quality of care issues as PPS was being implemented. By October, 1984, all non-exempt hospitals were being reimbursed by Medicare under PPS, and almost all of the 54 PROs were operational.

As the PROs became operational, they began encountering situations that involved premature discharges and inappropriate transfers. Either of these situations could indicate a hospital and/or a physician attempting to circumvent or "game" the system.

Premature Discharges/Inappropriate Transfers

A premature discharge is the release of a patient who is still in need of acute hospital care. If the patient returns to the hospital, the hospital receives a second DRG payment. If the patient does not return to the hospital, the hospital still benefits financially by having expended less of its resources than would have been expended had the patient stayed until acute level care was no longer required.

An inappropriate transfer is the transfer of a patient, for no discernable reason, from an acute hospital to another acute hospital or from an acute hospital to an exempt non-PPS unit (e.g. rehabilitation, psychiatric, and alcohol/drug treatment units). The Medicare program suffers financially when patients are inappropriately transferred back and forth because each facility involved receives reimbursements either through DRGs, per diem payment, or on a cost basis.

MREs, FIs and subsequently PROs were required to review all readmissions to a hospital within seven days, and all patient transfers. Instructions regarding the identification and processing of these cases were contained in HCFA's Transmittal 107 issued in November, 1983, and are now incorporated into the PRO manual. These initial instructions dealt only with cases that were determined to be medically unnecessary stays or medically unnecessary transfers. If the care rendered during the readmission or following the transfer was determined to be unnecessary, denial of the second stay could be made. If a pattern of unnecessary admissions or transfers was identified, development of a sanction recommendation was to be initiated if violations of Section 1156 of the Social Security Act were in evidence.

Falling outside of the scope of the initial instructions issued by HCFA were instances of premature discharges and inappropriate transfers where the resulting stay was medically necessary, or the reason for transfer was not apparent, although the care was necessary.

These cases were to be referred into the HCFA regional offices for analysis, pending a Departmental legal decision regarding how to implement the authorities under Section 1886(f)(2) of the Social Security Act, which authorizes PROs to deny stays and initiate sanction action in instances where PPS is being manipulated or circumvented. It was assumed by HCFA that the PROs would handle any quality issues associated with these cases in accordance with PRO authorities and procedures. These provide for educational contacts, intensified review and ultimately sanction of providers if violations of Section 1156 are identified.

In July, 1985, HCFA issued Transmittal 5, which instructed the PROs to deny payment in certain circumstances for

readmissions resulting from premature discharges and for inappropriate transfers, and to initiate sanction development based on prescribed criteria.

III. Case Reconciliation

- o Of the 4,724 premature discharge and inappropriate transfer referrals reported by the HCFA regional offices from 10/1/83 through 5/31/85, 2,688 (57%) of the cases could be located.
- o Of the referral cases, 2,165 were reported by HCFA to be MRE/FI referrals and 2,559 were PRO referrals. Seventeen percent (370) of the MRE/FI referrals and 91% (2,318) of the PRO referrals were located during this study.
- o In addition, 282 cases referred after 5/31/85 were reviewed and 736 cases that were never referred were identified and categorized.
- o In all a total of 3,706 cases were reviewed, 3,549 of which were categorized as premature discharges and inappropriate transfers.

To put these numbers in perspective, it should be noted that from implementation of PPS through May, 1985, MREs/FIs and PROs reviewed, for a variety of reasons, approximately 2.1 million cases. The 4,724 referrals made to HCFA were contained in a universe of approximately 345,700 cases which were targeted for review because there were two admissions within a seven day period or the patient was transferred. Identified premature discharges and inappropriate transfer cases referred to HCFA by the PROs account for approximately 1.4% of this specific universe.

However, because of inconsistencies, inaccuracies and non-reporting, any broad conclusions regarding premature discharges and inappropriate transfers, based on these figures, would be unfair and inaccurate. Also, the 1.4% excludes cases where the discharge, while premature, did not result in a readmission; the readmission occurred after seven days; or the readmission was at another hospital.

It was anticipated that the referrals made prior to PRO implementation might be difficult to locate, and indeed only 370 (17%) of the 2,165 MRE/FI referrals could be found. It appears that most of the case information was destroyed or warehoused by the MREs/FIs when the PROs became operational.

In a few regions PRO referrals were also hard to find. In some instances, case summaries supporting the actual numbers reported on the monthly HCFA-516s, the designated HCFA form for reporting premature discharges and inappropriate transfers, could not be located or the identifying information on the referrals was not complete enough to associate it with a HCFA-516. This made categorization of those cases impossible. On-site visits to the PROs became more difficult because the PROs were required to locate the referral cases without identifying information and then document action on quality issues. Because of this confusion, 282 cases referred into HCFA after 5/31/85 were categorized, as well as 736 cases that were found on-site at PROs that had never been referred. In all a total of 3,706 cases were reviewed in this inspection.

Explanations for the difficulty in finding the referral cases varied. HCFA, in issuing instructions regarding these referrals, did not stipulate a format or the type of information that should be contained in the referrals. The regional offices did not give uniform instructions to PROs regarding these referrals. Some regions indicated they wanted only the number counts, while others issued explicit instructions on what to send in, including cases involving quality issues or anything that was of a sensitive nature.

Due to the inconsistency of the instructions the PROs were confused regarding their reporting responsibilities. This is evidenced by the disparity in the number of cases reported by each PRO and in the 30% of PROs who referred no cases at all. There is also no direct relationship between the number of cases referred, Medicare hospital utilization within the state, or review activity by the PROs. In addition, of the cases that were located and identified, 157 (4%) were inappropriate PRO referrals that did not involve premature discharges or transfers. The chart on page nine indicates total referrals reported on the HCFA-516s, and case summaries actually located.

The lack of referrals and inconsistent referral rates can be attributed to systems problems experienced by FIs and PROs in identifying these cases; unclear, misunderstood, or disregarded instructions; duplicate counts; amended HCFA-516 reports; and confidentiality concerns by the PROs.

Of the 3,706 cases reviewed, 3,336 (90%) were referred in by PROs, 208 (6%) by MREs, and 162 (4%) by FIs. Eliminating the inappropriate referrals reduces the case count to 3,549. It is these 3,549 cases which are discussed in the body of this report.

CASE RECONCILIATION

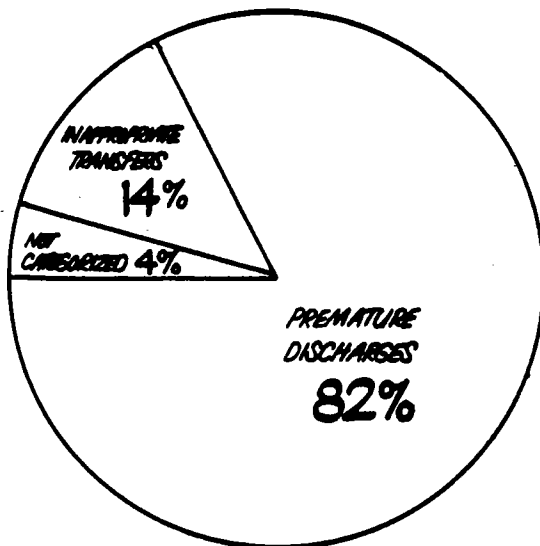
CASES REPORTED BY HCFA 10/1/83 - 5/31/85	CASES FOUND	PERCENT FOUND
MREs/FIs 2165	370	17%
PROs 2559	2318	91%
TOTAL 4724	2688	57%
CASES REPORTED AFTER 5/31/85	282	
CASES NOT REPORTED	736	
TOTAL CASES FOUND	3706	
LESS ERRONEOUS REFERRALS	157	
TOTAL	3549	

IV. Categorizing Cases and Documenting Dispositions

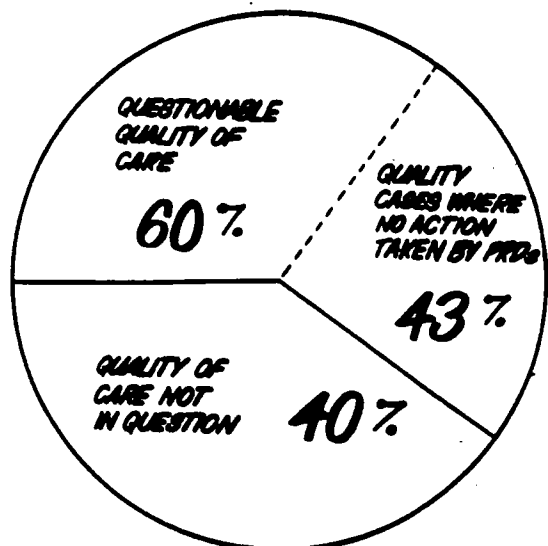
- o Of the 3,549 cases reviewed, 2,907 (82%) were identified as being premature discharges, 491 (14%) were inappropriate transfers and 151 (4%) could not be categorized by type because of insufficient information.
- o Of these cases, 2,146 (60%) were identified as quality issues by the PROs.
- o In 927 (43%) of the cases where quality issues were identified, the only apparent action taken was referral to the HCFA regional offices.
- o Of the cases with apparent quality issues, 133 patients' records were referred to OIG physician consultants to review the appropriateness of PRO action.
- o PRO action was found to be inappropriate in 106 of the 133 cases reviewed by the OIG.

Quality issues were coded when a PRO physician advisor had identified them in case documentation. It should be noted that the magnitude of the quality issues identified by the PROs varied from very minor to potentially very serious. However, the review teams did not attempt to categorize the severity of the issues.

CATEGORIZE CASES



QUALITY ISSUES



Premature Discharges

The premature discharges discussed in this review were identified as such by the PROs in their reviews of a subsequent readmission to the same hospital. The PROs referred these cases to the regional offices because the patients:

- o were not appropriately treated - (quality issue);
- o were appropriately treated but released too early in the course of treatment - (quality issue);
- o were discharged in a medically-unstable condition-(quality issue); or
- o were discharged to be readmitted for further treatment when all treatment could have been rendered in the first admission. (Generally these cases did not involve quality concerns.)

If a patient is released prematurely it is almost always at the physician's direction. However, there may be extenuating circumstances. In 2,035 (70%) of the 2,907 premature discharges reviewed, it appeared the physician was solely responsible for the discharge. In the remaining 30% of the cases the discharge was not directly attributable to the physician. For example:

- 1) In 669 (23%) of the premature discharges, the patient was admitted for a diagnostic workup, released, and readmitted for surgery. These situations included cardiac catheterizations with readmissions for bypass surgery and biopsies with readmissions for major surgery. The first situation is standard in many hospitals: the bypass surgery is not scheduled until the results of the catheterization are known. The second is frequently due to the patient's wish to settle his/her affairs before major surgery. Technically, these patients are still in need of acute care and fall into the category of premature discharges.
- 2) In 89 (3%) of the premature discharges, the patient was discharged at his or her own request or the family's request.

- 3) In 27 (1%) of the cases, the patient left the hospital against medical advice.
- 4) In 87 (3%) of the cases, miscellaneous reasons accounted for the discharge.

In a very few (12) instances, as annotated in the record reviewed, the physician discharged the patient because the physician had presumably been informed by the hospital administration that the resources expended on the patient were going to exceed the DRG payment, causing financial loss to the hospital.

The PROs also identified cases in which the patient was discharged as no longer needing acute care but was unable to manage at home, necessitating a readmission. A possible explanation for these situations is poor discharge planning. The patient should have been placed in a skilled nursing facility or referred for home health services. However, based on the sometimes limited information available, it was difficult to determine if readmission was due to poor discharge planning or a premature discharge.

Inappropriate Transfers

Generally, a transfer is necessitated by the inability of a hospital to provide a necessary service or a procedure, or because a patient is in need of a specialized therapy, i.e., rehabilitative or psychiatric care. The initiation of a transfer is based on an order by the attending physician who determines the level and type of care the patient needs.

Of the 491 transfer cases reviewed, the majority of patients, 388 (79%), were transferred from one acute care hospital to another; 17 (4%) to a rehabilitation unit; 11 (2%) to a psychiatric unit; and in 39 (8%) of the cases the destination was not known.

In 36 (7%) of the cases reviewed, patients were "transferred" inappropriately to skilled nursing facilities or swing beds. By HCFA definition, a patient is admitted to these facilities, not transferred. However, for purposes of this review, these cases were considered transfer cases.

In 289 (59%) of the transfer cases reviewed, the PRO determined no valid reason for transfer existed. The remaining transfer cases represented situations where an inappropriate transfer did occur but could not be attributed to the physician or hospital. They are as follows:

- 1) In 143 (29%) of the transfer cases reviewed, requests for transfer were made by the family. In some of these cases, the patient had been admitted to a community hospital that did not have the expertise to complete tests and perform necessary procedures. Therefore, the patient was appropriately transferred to a larger tertiary hospital which, in some rural areas, could be located a great distance from the patient's home, family and friends. Once necessary tests and procedures were performed, the family or patient requested transfer back to the community hospital for convalescence, which could have taken place in the tertiary hospital.
- 2) In 51 (10%) of the cases, miscellaneous or unclear reasons accounted for the transfer.
- 3) In 6 (1%) of the cases, the patient refused treatment at the receiving hospital and was sent back to the transferring hospital.
- 4) In two cases, documentation in the record indicated that a patient was transferred from an acute care setting to a specialty unit because if he/she stayed in the acute hospital longer he/she would exceed the "average length of stay", hospital resources expended might exceed DRG payment, and the hospital might suffer a financial loss.

PRO Disposition of Cases With Quality Issues

PRO follow-up activities were generally categorized into educational contacts, intensified review, and referral to HCFA only. In 927 (43%) of the 2,146 cases with identified quality issues, no action other than referral to HCFA was taken. The remaining actions taken by the PROs when quality issues were identified are categorized as follows:

1) Educational Contacts

In 743 (35%) of the cases, the PROs made educational contacts. The educational contacts ranged from sending the attending physician and hospital utilization review (UR) committee a copy of the referral to HCFA; to a telephone call to the attending physician by the PRO physician reviewer; to a carefully documented letter to the physician with a copy to the hospital UR committee detailing the PRO's analysis of the case. Many more of the former two practices were noted in this review. In very few instances was the phone call well documented, giving any details of the conversation, date or time. In some cases contact was made with the hospital UR committee instead of the physician, or in addition to the physician.

2) Further Review Determined No Problem Evident

In 208 (10%) of the cases it was determined that based on either additional information or review by a second PRO physician, there was no quality issue involved.

3) Intensified Review

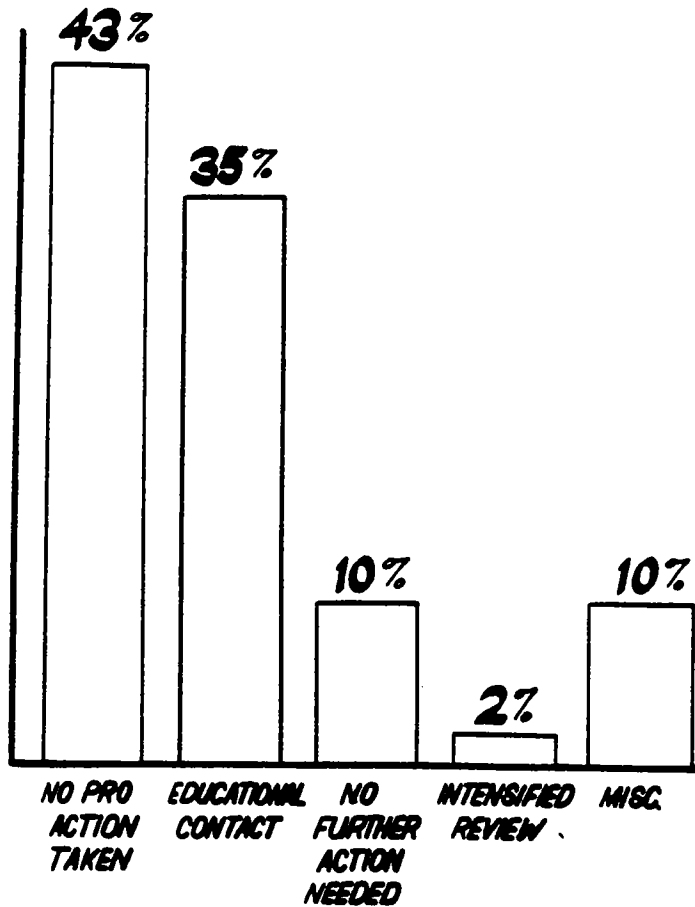
In 64 (3%) of the cases reviewed the PROs instituted intensified review of the hospital or physician.

4) Sanction Development

In no instance was a sanction development initiated by the PROs.

In 204 (9%) of the cases, actions such as referral to the PRO quality assurance committee; PRO development underway; PRO unable to locate record; etc., were recorded in a miscellaneous category.

PRO DISPOSITION OF CASES WITH QUALITY ISSUES



Quality Issues

Sixty percent of all cases reviewed involved quality concerns. The quality issues ranged from very minor to gross instances of substandard care. Of the 2,146 cases identified as having quality concerns, 2,050 were premature discharges, 42 were inappropriate transfers, and 54 were diagnostic workups with a readmission for surgery. It should be noted that not all of the 2,907 cases identified as premature discharges were classified as being quality issues. Generally the diagnostic workups with readmissions for surgery, while classified as premature discharges by HCFA definition, did not involve substandard care. Prior to PPS this was acceptable hospital practice. In addition, quality of care was generally not a concern in transfer cases. However, some patients were transferred in unstable condition or for inappropriate care, and some of the patients sent home to await surgery deteriorated in the interim.

Substantive issues accounted for the vast majority of the cases reviewed. The types of situations which were identified most often included:

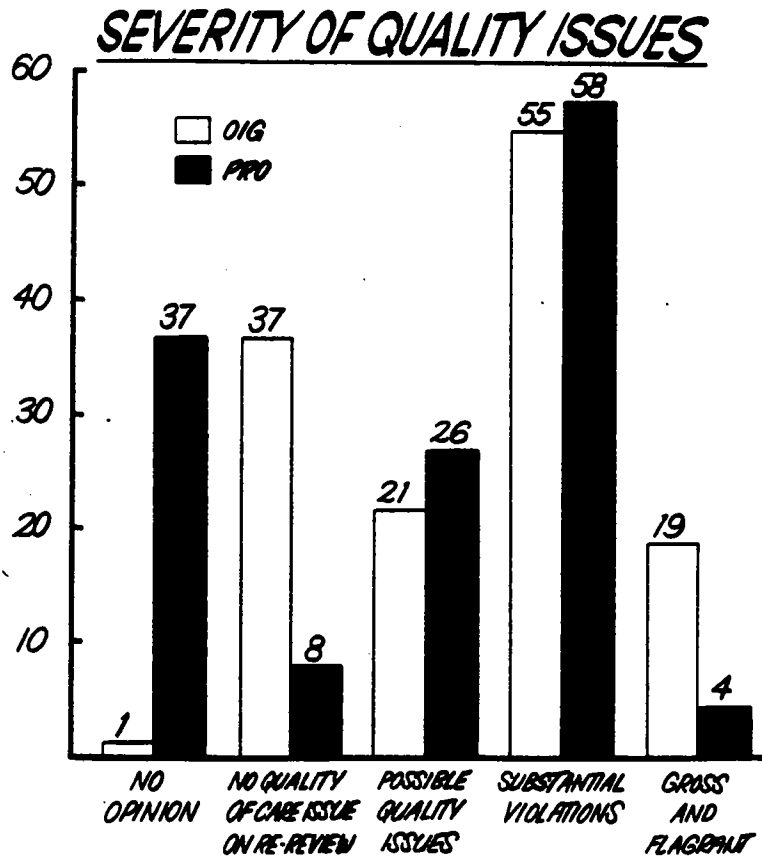
- 1) conditions not adequately treated, such as indications of urinary retention, infection, etc., being acknowledged but not addressed prior to discharge;
- 2) secondary conditions uncovered by laboratory analyses not being acknowledged or addressed until readmission;
- 3) failure to perform routine laboratory tests, or failure to document vital signs, leading to missed diagnoses.

All of these cases had been identified as quality concerns by the PRO physician reviewers. When the OIG reviewers saw cases in which the situations above appeared to have placed the patient in great jeopardy, copies of the medical record were requested for further review by OIG physician consultants.

The OIG physicians reviewed medical records for 133 patients and, if attached, PRO worksheets and opinions by nurse reviewers or PRO physician advisors. After analysis,

the cases were then grouped into the following categories: gross instances of poor quality of care; substantial instances; possible instances; no instance of violation; and no opinion of the case reviewed. PRO physicians' comments on these cases were also categorized. The result is displayed on the following chart:

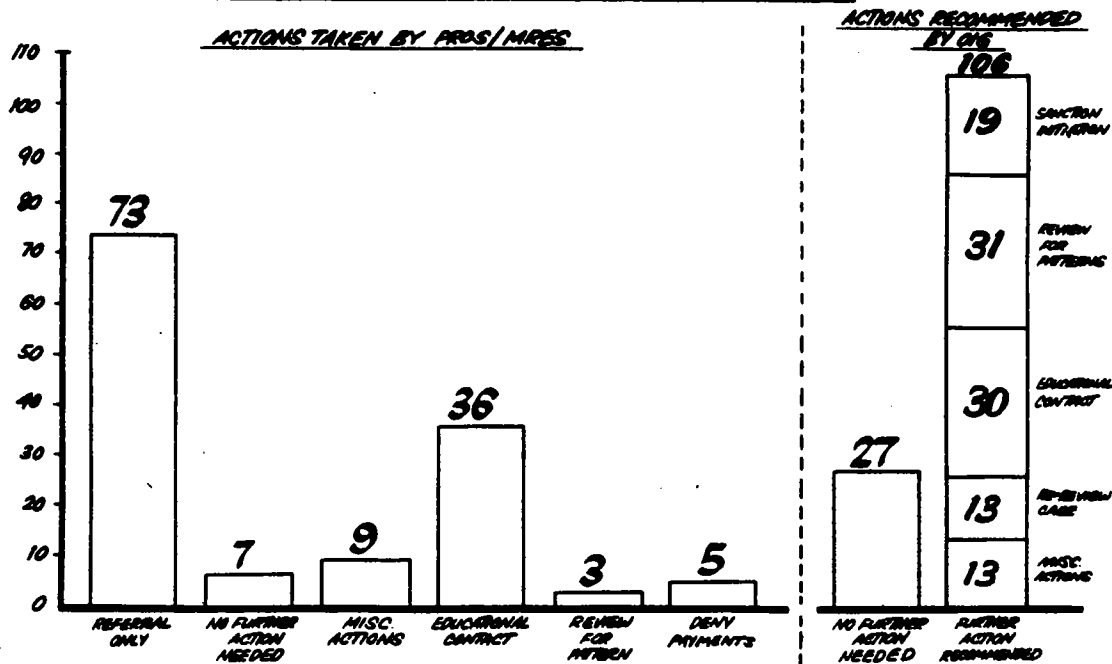
OIG MEDICAL REVIEW OF 133 CASES



In 73 (55%) of the 133 cases, PROs referred the cases to HCFA and no further action was taken. In 36 (27%) of the cases an educational contact was made. In the remaining cases a number of actions, such as referral to the PRO quality assurance committees, were made. In no instance was a sanction development initiated.

OIG physicians recommend that sanction development be taken in 19 (14%) of the cases; additional review of more recent cases be done on specific hospitals and physicians identified in 31 (23%) of the cases; educational contacts be made in 30 (22%) of the cases; no additional action in 27 (21%) of the cases; and rereview of the case by the PRO in 13 (10%) of the cases. In the remaining 13 (10%), various other actions are recommended.

OIG MEDICAL REVIEW OF 133 CASES



In summary, medical records for 133 patients were reviewed by OIG physician consultants. It was their opinion that 19 of these cases represented instances of gross and flagrant violations. Fifty-five represented substantial violations of acceptable medical practice, 21 represented possible violation, 37 cases had no quality issues on re-review, and in one case OIG physicians did not have sufficient information to render an opinion. Thirty-eight cases with identified quality issues where inappropriate actions were taken by the PROs have been returned to them for sanction development. The remaining cases are currently being reviewed by HCFA.

V. Mechanisms to Address Cases of Premature Discharge or Inappropriate Transfer

- o The profiling of physicians and providers necessary for the identification of abusive patterns is for the most part being done manually by the PROs.
- o HCFA instructions pertaining to inappropriate discharges and transfers were well received by some PROs, but many expressed a need for further clarification.
- o Sanction recommendations regarding these cases are not being made by the PROs in accordance with available PRO authorities.

Based on the findings of this inspection it appears that many PROs have not effectively used the authority or the process available to them to address instances of premature discharge and inappropriate transfer. This is due in part to their inability to identify patterns of abuse, the lack of clarity and adequacy of HCFA instructions pertaining to these cases, and an apparent reluctance to implement corrective actions and carry out educational responsibilities when instances have been identified.

The prevention of premature discharges and inappropriate transfers is part of the PROs' ultimate goal of protecting the integrity of the system while safeguarding the quality of care provided through this system.

The process enabling the PROs to address premature discharges and inappropriate transfers involves:

- 1) identification, tracking and profiling of providers and physicians;
- 2) review and assessment of the appropriateness and quality of care;
- 3) use of corrective measures and communicative approaches designed to educate and instruct providers and physicians, as well as denial of payment and sanction actions.

Identification and Profiling

HCFA requires that all PROs have profiling capabilities. Yet, very little profiling was being done of the providers and physicians identified in the premature discharges and inappropriate transfers reviewed in this inspection. Profiling that was occurring was for the most part being done manually.

A total of 1,158 hospitals could be identified in this study, 392 of which had three or more cases identified as being premature discharges or inappropriate transfers. One hundred eighty-five had five or more cases identified, 85 had eight or more instances and 53 hospitals had 10 or more instances identified during the time frames of this review. Those hospital providers identified as having more than 10 instances of premature discharges and inappropriate transfers will be brought to the PRO's attention by HCFA for additional development to determine if patterns of substandard care exist.

In order for the current system to work, it is essential that individual instances of premature discharges and inappropriate transfers be identified and dialogue initiated with the physicians and hospitals involved to prevent further occurrences.

Under current policy the denial of the second stay should serve to deter the physician and/or hospital from manipulating or circumventing the system, but it will not facilitate the identification of patterns of poor quality care unless profiling of physicians and hospitals also occurs.

Due to the heavy volume of cases reviewed by the PROs it is essential that profiling of quality issues be automated. Not only would this provide for accurate tracking and analysis, it would also facilitate HCFA monitoring processes and PRO reporting responsibilities.

HCFA Instructions

The issuance of Transmittal 5 addressed in part situations where premature discharges and inappropriate transfers were occurring. HCFA provided guidance to the PROs on how to handle certain situations that were in violation of Section 1886(f)(2) of the Social Security Act. Generally,

the PROs were glad to receive the instructions contained in Transmittal 5. However, when asked if the instructions were adequate and could feasibly be incorporated into the existing processes, they were less unanimous in their responses.

Half of the PROs felt that the instructions were not realistic and need further clarification. The focus of many of the PROs' concerns revolved around the denial of the second hospital stay rather than the first (which resulted in the premature discharge). Also, they appeared to be somewhat unclear regarding the hospital appeal rights should payment be denied and the effect of waiver of liability in these situations, although these issues are addressed in Transmittal 5.

Some PROs felt the criteria stipulated by HCFA which would indicate a pattern of circumventing PPS and necessitate initiation of a sanction development was not consistent with the current sanction procedures. PROs also felt that the trigger of a sanction development based on three inappropriate transfers or premature discharges in a quarter would unfairly penalize larger hospitals. Related concerns expressed by the PROs are the potential effect on their staffing and budgets that would result from increased sanction activity.

Not covered in these instructions are situations where a patient is readmitted to a different hospital. In addition, the instructions do not address premature discharges that do not result in another hospital stay, nor do they apply if the patient or family requests the discharge. Also not addressed are situations where proper discharge planning would have prevented the necessity for the second admission.

Areas that were not clear to the PROs were:

1. Effective date of the instruction.
2. Whether the criteria triggering initiation of a sanction applies to an individual physician or the hospital.
3. Whether to:
 1. Recommend sanction based on
 - A. quality which does not meet professionally recognized standards under Section 1156(a)(2) of the Social Security Act; or
 - B. circumvention of the system, Section 1886(f)(2); or
 2. Refer for termination of the provider agreement under 1866(B)(2).
4. Whether the requirement to refer premature discharges and inappropriate transfers into HCFA via the HCFA-516 is still in effect.

Use of Educational, Preventive, and Corrective Measures

Prior to issuance of Transmittal 5 in July, 1985, the PROs were not authorized to deny payment for premature discharges and inappropriate transfers, pending a legal determination regarding the propriety of this action. Although PROs now have instructions regarding this authority, it is too early to determine if the financial loss to hospitals resulting from the identification of such practices will serve as a deterrent in the future. However, PROs have always had the responsibility to document patterns of substandard care and initiate corrective actions.

With the issuance of Transmittal 5 the PROs have received instructions and been given criteria that if met should trigger a sanction development based on circumvention of PPS.

A number of PROs expressed the opinion that if they were adequately performing their educational and preventive

role, punitive actions would not have to be taken as frequently. Indeed the current process encourages an early warning to a physician or hospital to prevent the necessity for drastic action later on.

However, as mentioned earlier, the PROs are not consistent in how often or to what extent educational contacts are made with the hospital physician community when poor quality care has been identified.

Documentation of educational contacts, whether phone calls or letters, could be found in fewer than half of the cases identified by the PROs as having indications of poor quality. In some instances, the OIG physician reviewer determined that, on available evidence, the care was in gross and flagrant violation, yet only a referral to the HCFA Regional Office had been made.

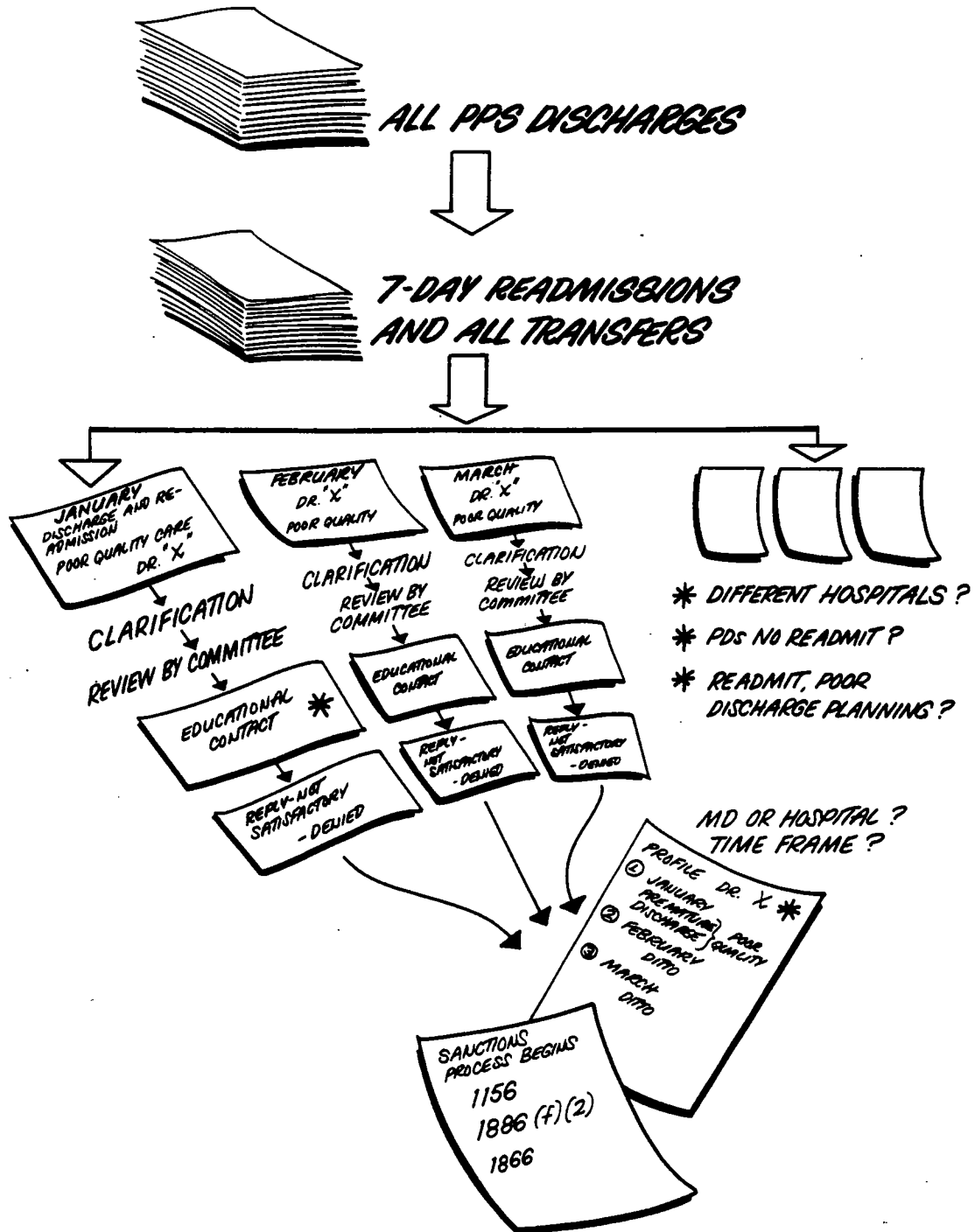
In instances where a copy of the letter sent to the physician was available, it frequently did not document the nature of the violation or the PRO's specific concerns.

It is essential to the PRO monitoring process to document that educational contacts of a specific nature have been made with physicians and hospitals when quality issues have been identified. It is also essential to the development of a sanction case should the necessity arise.

There was no uniformity or consistency in the cases reviewed regarding: when an educational contact was made; the content of the notification; with whom the contact was made; or documentation of the contact.

The following is a diagram of the process to identify, track, and prevent the occurrence of premature discharges and inappropriate transfers. Asterisks are used to identify weaknesses in this process that have been discussed throughout this report. Correction of these weaknesses and aggressive use of this process by the PROs should prevent occurrences of premature discharges and inappropriate transfers in the future.

PROCESS



VI. Recommendations

1. HCFA should:

- o Continue its reporting requirements regarding premature discharges and inappropriate transfers. Instructions regarding PRO referrals should be clarified and a uniform format for referrals developed. Uniform PRO referral of these cases will help to identify the magnitude of this problem and assess the effectiveness of the policies contained in Transmittal 5.
 - o Issue clarification of Transmittal 5 immediately, in response to specific PRO concerns.
 - o Expand the PROMPTS review to include monitoring of a sample of referral cases, from identification through PRO corrective actions, to ensure the process for handling these cases is being correctly implemented.
 - o Reassess, through PROMPTS, PRO operational procedures and systems for identifying, profiling and tracking instances of poor quality care attributable to physicians and hospital providers. PROs should have the automated capability of identifying patterns of substandard care. Deficiencies or system problems should be noted and corrective actions taken.
 - o Provide direction to the PROs regarding the issuance, content, and documentation of educational contacts made prior to sanction development.
 - o Initiate studies to determine the extent to which poor discharge planning is resulting in hospital readmissions.
2. The OIG concurs with HCFA that PRO scopes of work should be revised to place more emphasis on PRO responsibility in monitoring quality of care.
3. The Department should continue to encourage passage of Senate Bill 1623, incorporated in the Senate Reconciliation package, which would authorize PROs to

deny payment for identified instances of substandard care, of a substantive nature, rendered to Medicare beneficiaries.



Memorandum

MAR 5 1986

Date
From
Subject
To

Henry R. Desmarais, M.D.
Acting Administrator
Health Care Financing Administration

OIG Draft Report-Inappropriate Discharges and Transfers (OAI-86-0050)

The Inspector General
Office of the Secretary

We have reviewed the report on inappropriate discharges and transfers under the Medicare Prospective Payment System. As recognized in the report, HCFA has already taken a number of actions to correct the problems referred to in the study and is continuing to move aggressively in identifying and resolving quality of care problems.

HCFA fully expects and requires Peer Review Organizations (PROs) to investigate quickly and thoroughly all cases where the quality of health care provided to Medicare beneficiaries does not meet professionally recognized standards of care. HCFA firmly believes this to be a basic purpose of peer review, and we intend to make certain that PRO performance in this area is in accord with our expectations through intensive monitoring by the regional offices (ROs).

The OIG study is of assistance to HCFA by identifying areas where further improvement by PROs and ROs in resolving quality of care issues can be attained, and we appreciate the time and resources the OIG expended in preparing this report.

Some general comments and observations about the report may be helpful in any future studies:

- o The study covered the period from October 1, 1983 through May 31, 1985. The sanction regulations became effective May 17, 1985 and Transmittal 85-5 was effective in July 85.
- o As noted in the report, 30% of the cases classified as premature discharges were not directly attributable to physicians but were reimbursement-related problems.
- o Review of the records provided to HCFA revealed only one case where the DRG payment was a factor in the premature discharge. HCFA needs to know the identity of the others, if any, referred to on page 12 so we can discuss them with the PRO, physicians and hospitals and take corrective action.
- o Forty-two percent (42%) of the cases classified as inappropriate transfers on page 13 are not inappropriate by OIG definition, i.e., they do not question the quality of care provided (page 5).

- o It is difficult to follow the arithmetic calculations used in the report. For example, we have been unable to determine exactly how many serious quality problems the OIG medical consultants believe were missed by PROs. Percentages are applied to various baseline numbers, percentages are taken of percentages, and numbers are not consistently used. HCFA recommends that future reports be uniform in the use of numbers and percentages.

We are taking the following actions in regard to the specific recommendations made in the report:

OIG Recommendation

Continue reporting requirements regarding premature discharges and inappropriate transfers. Instructions regarding PRO referrals should be clarified and a uniform format for referrals developed. Uniform PRO referral of these cases will help to identify the magnitude of this problem and assess the effectiveness of the policies contained in Transmittal 5.

HCFA Comments

We agree. The PRO will be required to refer to the RO only those cases that cannot be resolved under existing instructions. Transmittals 85-5 and 85-6 require PROs to take action on premature discharges and transfers in most instances. Only cases for which there is no existing policy should be sent to the RO. Concurrently, we will require that the PRO report to the RO, on a monthly basis, the number of cases identified as premature discharges or inappropriate transfers. The RO will also be responsible for responding promptly to the PRO on the referred cases. In addition, ROs will verify the accuracy of the report on premature discharges and transfers and will insure that PROs take appropriate action on these cases.

OIG Recommendation

Issue clarification of Transmittal 5 immediately, in response to specific PRO concerns.

HCFA Comments

We agree. Clarifications will be released shortly and will resolve the concerns identified by ROs and PROs. In addition, HCFA, in conjunction with the Office of General Counsel, is in the process of rewriting 85-5 both to expand its application and to clarify its content.

OIG Recommendation

Expand the PROMPTS review to include monitoring of a sample of referral cases, from identification through PRO corrective actions, to ensure the process for handling these cases is being correctly implemented.

HCFA Comments

ROs are currently required to review a sample of cases as part of PROMPTS. This activity will be modified to verify that cases are appropriately handled.

OIG Recommendation

Reassess, through PROMPTS, PRO operational procedures and systems for identifying, profiling and tracking instances of poor quality care attributable to physicians and hospital providers. PROs should have the automated capability of identifying patterns of substandard care. Deficiencies or system problems should be noted and corrective actions taken.

HCFA Comments

We agree. "Profiling" to identify and focus on problems is a prerequisite to effective peer review. We will be providing additional technical assistance in this area and aggressively enforcing requirements that PROs effectively profile information obtained through review to identify inappropriate patterns of care.

OIG Recommendation

Develop guidelines and model letters regarding issuance, content, and documentation of educational contacts made prior to sanction development.

HCFA Comments

We do not believe it is appropriate for us to put forth model letters in this area, and we have been informed by the OIG that they did not mean to require this. OIG agreed that the process and methods to be used in educational contacts is a local responsibility. We will, however, monitor this activity by reviewing documentation to assure that the actions taken are effective in correcting the problem.

OIG Recommendation

Initiate studies to determine the extent to which poor discharge planning is resulting in hospital readmissions.

HCFA Comments

We are currently funding studies by six PROs to identify the extent of the premature discharge problem and to identify the most effective review methodologies for dealing with it.

OIG Recommendation

The OIG concurs with HCFA that PRO scopes of work should be revised to place more emphasis on PRO responsibility in monitoring quality of care.

HCFA Comments

The scope has been revised to focus on quality of care issues through the use of generic screens and more focused review.

OIG Recommendation

The Department should continue to encourage passage of Senate Bill 1623, incorporated in the Senate Reconciliation package, which would authorize PROs to deny payment for identified instances of substandard care, of a substantive nature, rendered to Medicare beneficiaries.

HCFA Comments

We concur.

We would like to offer the following comments in regard to the other findings in this report.

Finding

Quality issues ranging from very minor to gross and flagrant were identified by the PROs in 60 percent of the 3,549 cases. PRO disposition ranged from intensified review of identified hospitals and physicians to no action being taken at all. In 43 percent of the cases with identified quality issues the only apparent action taken by the PRO was referral to HCFA.

Response

We agree with this finding. The ROs are currently aggressively monitoring PRO activity in quality of care cases to assure that appropriate corrective action is taken.

Finding

Medical records involving 133 patients were referred to OIG physician consultants for review. Nineteen were classified by OIG consultants as exhibiting gross and flagrant instances of substandard care. PROs took no corrective action, other than referral to HCFA, on 12 of these 19 cases. In the opinion of the OIG medical consultants, inappropriate actions were taken on 106 of the 133 cases. These cases have been or will be returned to the PROs for various recommended actions.

Response

While we cannot ascertain from the report how many cases the PRO did not handle appropriately, we have completed medical record review on the 77 cases made available to us by the OIG. These cases did reflect apparent inadequate PRO intervention. These cases are being transferred to the ROs for control and return to the PRO. The ROs will be responsible for assuring that the PRO develops them and takes necessary corrective action.

Finding

PROs did have the authority to take action on the quality issues identified in this study. It appears that many PROs have not effectively used the authorities or the processes available to address instances of poor quality care associated with premature discharges and inappropriate transfers.

Response

We agree that PROs had the authority to take action on any quality issues identified by them or brought to their attention through the OIG, the fiscal intermediary, HCFA or any other source. ROs, during onsite visits and in other communications with PROs, are monitoring actions taken by PROs in resolving cases of unacceptable quality of care in any category, i.e., surgery, drug, premature discharge, unnecessary admissions, inappropriate transfers, etc. PROs found out of compliance with these requirements will be subject to contractual enforcement actions.

Finding

During OIG site visits conducted in September and December 1985, problems were noted with the PROs' accumulation of data pertaining to the quality of care rendered by physicians and hospitals. This data is necessary for the identification of abusive patterns and subsequent corrective action.

Response

HCFA is preparing an instruction that will further define the PROs' responsibility for maintaining profiles to be used in analyzing quality of care problems and in identifying aberrant providers or physicians. Corrective action will be taken against any PROs unable or unwilling to monitor quality of care through profile analysis. HCFA has emphasized to the ROs that aggressive monitoring and timely and complete profiling is required of all PROs.

Finding

It should be noted that since the initiation of this inspection increased activity by HCFA and the PROs in this area has occurred. HCFA has issued Transmittal 6 (relating to sanction procedures) and has initiated focussed reviews in this area. PROs are increasing sanction activities against physicians/providers demonstrating abusive patterns of practice.

Response

Current reports show greatly increased activity in the identification and development of cases by the PROs that may be violations of obligations, and in the issuance of first notices where a violation has been determined. In those PROs where activity remains minimal, we are directing the ROs to review the PRO's application of Transmittals 85-5 and 85-6 and to take immediate corrective action if those instructions are not being followed.