AMAZING THINGS ARE HAPPENING HERE

New York - Presbyterian Hospital
RAC Lessons Learned
Medicare's Recovery Audit Contractor (RAC) Program

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New York - Presbyterian Hospital

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NewYork-Presbyterian
The University Hospital of Columbia and Cornell

New York - Presbyterian Hospital 2008 Key Statistics-NYP.ORG

- Five Centers of New York-Presbyterian Hospital
  - The Allen Pavilion
  - Morgan Stanley Children's Hospital
  - New York-Presbyterian Hospital/Columbia University Medical Center
  - New York-Presbyterian Hospital/Weill Cornell Medical Center
  - New York-Presbyterian Hospital/Westchester Division
- Certified Beds – 2,242
- Discharges – 112,000
- Outpatient Visits – 1,500,000
- Emergency Visits – 231,000
- Ambulatory Surgery Visits – 74,000
- Employees – 16,000
- Physicians – 5,500
- Two Medical Schools
  - Columbia University College of Physicians & Surgeons
  - Weill Medical College of Cornell University
- Medicare Indemnity Patient Mix – 25%
- Total Revenues - $2.9 billion

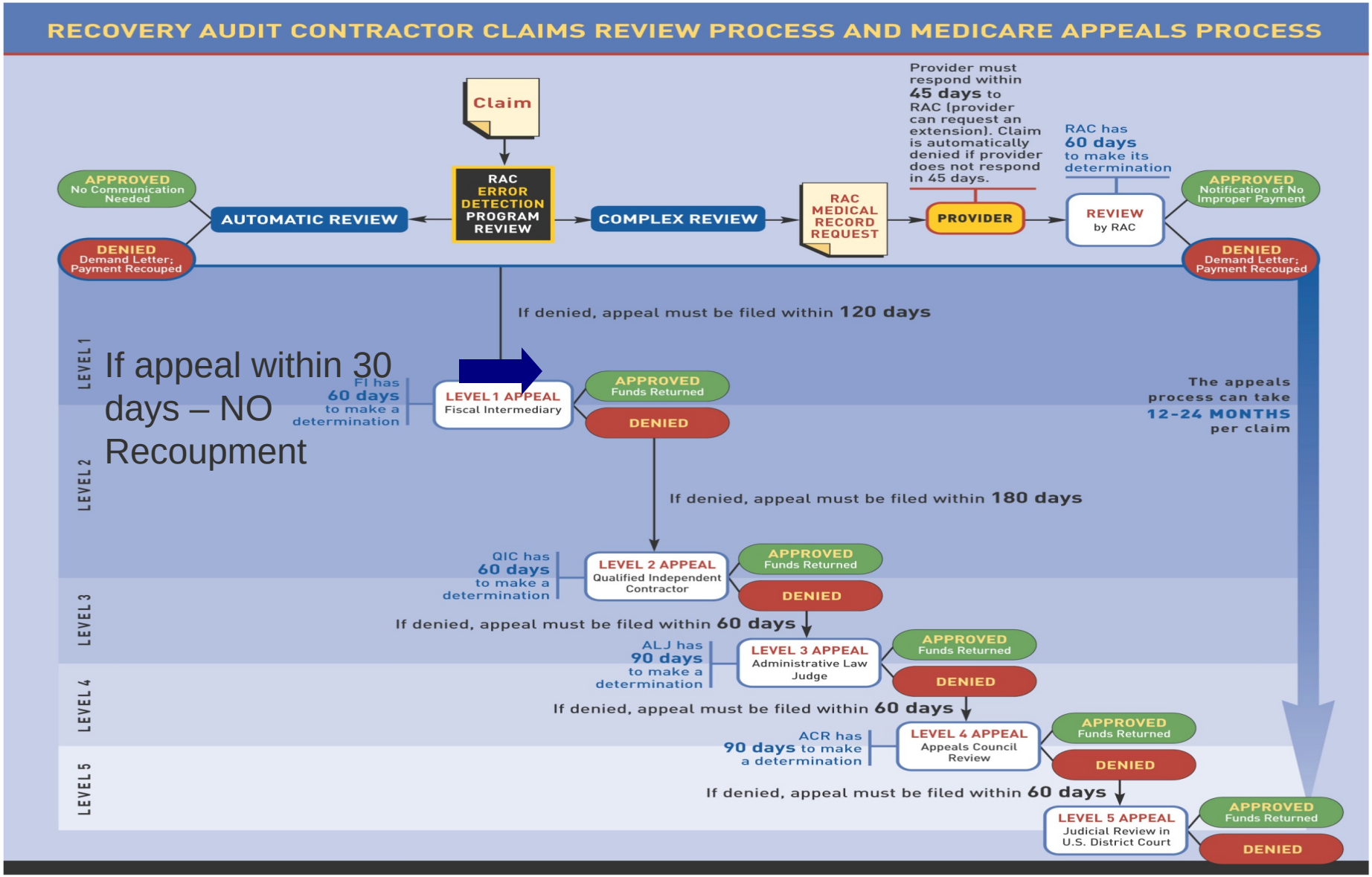
The NYPH RAC Team

- Patient Case Management (PCM) - medical necessity reviews
- Patient Financial Services (PFS) – tracking all RAC activity, including payments and denials.
- NYPH Operations – other outpatient documentation reviews
- Health Information Management (HIM) – coding, DRG assignment reviews
- NYPH Corporate Compliance –general regulatory oversight
- Finance/Reimbursement & General Accounting – other financial tracking
- Charge Master Department (CDM) – other outpatient service reviews
- Clinical Departments – as needed

RAC Claims Review and Medicare Appeals Process

- Levels of Appeal
  - Level 0 – Appeal to the Recovery Audit Contractor
  - Level 1 – The Fiscal Intermediary or Medicare Administrative Contractor
  - Level 2 – Qualified Independent Contractor
  - Level 3 – Administrative Law Judge
  - Level 4 – Appeals Circuit Review
  - Level 5 – Judicial Review in U.S. District Court
- Timelines and Deadlines
  - The appeals process requires strict adherence to published guidelines.
  - The burden of logging and tracking all RAC activity rests with the providers throughout the appeals process. Missed deadlines translate into lost revenue.

RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS



New York Experiences

- **Administrative Burden on Providers**
  - Lack of electronic platform between contractor and provider - a “paper” nightmare.
- **GNYHA assisted in developing a RAC Liaison contact data base for the contractor**
- **GNYHA developed an Access RAC Tool**
  - Helped providers track claims over the timeline
- **Hospitals continue to struggle with:**
  - Inpatient coding issues
  - One day inpatient stays; both surgical and ED admits
  - Outpatient billing guidelines
  - Unanswered questions from CMS
- **Cost Report reconciliation**
  - Take-backs from prior years
- **Beneficiary refunds**
  - Changes in co-insurance amounts

Assembling Your RAC Team

- Questions?
  - Why does my facility need a RAC Team?
  - Who in my facility should be the RAC Coordinator or Liaison?
  - Which departments within my facility should be represented on the RAC Team?
  - How often should the team meet?
  - What should the team discuss when they meet?
  - What are some of the key roles of team members to insure a successful RAC Team?
  - Should physicians be members of the team?

A New York Multi-Campus >2,000 Bed Hospital's Approach to the RAC Team

- Patient Financial Services – RAC liaison and staff:
  - Coordinates RAC team meetings and discussions;
  - Receives and tracks all RAC requests and correspondence;
  - Coordinates medical documentation and appeal submissions to the RAC and /or CMS;
  - Reports RAC activity to senior management.
- Patient Case Management:
  - Reviews all medical record requests for medical necessity of setting and documentation to support billed setting. Applies predictability indicators to medical necessity of setting prior to chart submission to the RAC.
- Health Information Management:
  - Reviews all medical record requests for appropriate assignment of DRG and documentation to support coding. Applies predictability indicators to coding prior to chart submission to the RAC.
- Hospital Operations:
  - Reviews documentation for outpatient medical record requests and RAC "Demand Letters" for accuracy and completeness.
- Other Departments:
  - Corporate Compliance, Legal, Finance

Clinical Staff Involvement

- Questions?
  - Why should our clinical staff, particularly physicians, be involved in the RAC process at all? Which clinical services lines should we target?
  - How do we get their attention?
  - How does RAC activity affect the clinical staff?
  - If I can get a group of clinicians together, which RAC issues would benefit from their involvement? And buy-in?
  - Which members of the RAC Team are best qualified to in-service the physicians on RAC issues?

Getting the Clinicians Engaged

How/Where To Start?

- Conduct in-services in key areas with high volume of short stays and often involving complex procedures (Interventional Cardiology, EPS, Vascular Service, Urology, Cardiology, Neurology, Emergency Department, etc.) with the physicians performing procedures, treating patients and documenting records and discuss:
  - Documentation to support the management of the patient;
  - Understanding the concepts of Inpatient, Outpatient, Observation, Extended Recovery from a setting perspective, without compromising the welfare of the patient;
  - Educating the clinical staff on how to word the order to “admit” the patient based on the anticipated outcome of the case;
  - Communicating openly with Case Managers and coders with respect to the quality of the documentation as it relates to the patient setting.
  - **Document, Document, Document!**

Clinicians' Reactions

- **Immediate Reactions**
  - The physician in-services, conducted by Health Information Management and Patient Case Management, were favorably received by all of the service lines reached to date. The physicians expressed concerns about hospital payments being at risk and were enthused to be able to assist in improving the day-to-day documentation issues. They were instrumental with their input on the appeals on the RAC Medical Necessity denials with NGS/CMS.
- **Next Steps**
  - Form a task force to review current processes around documentation and appropriateness of patient setting.
  - Identify some best practices both within New York State and around the country. Research field experts and possibly engage assistance from outside vendors.

NYPH's RAC Strategy & Getting Ready for the "New" RAC

- The NYPH's RAC Team aggressively appeals all overpayment decisions where the medical necessity of the IP setting or the coding of a DRG can be supported by:
  - Validating that the appropriate coding clinics were referenced by coding staff for the date of discharge;
  - Reviewing NYPH's policies and protocols for admitting patients, in conjunction with an established IP criteria screening tool, and regulations in effect during the periods in question.
- **FOR THE NEW RAC**

  In anticipation of the RAC Expansion Project, NYPH plans to continue internal reviews of Medicare & non-Medicare cases for documentation to support an inpatient setting and DRG coding assignments by:
  - Performing documentation reviews (Documentation Improvement Initiatives) for complicating/co-morbid conditions which may appropriately justify the inpatient setting;
  - Analyzing internal short-stay data for trends;
  - Assessing resources if chart request volume increases from the RAC Demonstration Project limits;
  - Developing additional education sessions for physicians aimed at improving documentation to support medical necessity and DRG assignments.

Lessons Learned

- **Tracking**
  - Meticulous tracking of all RAC correspondence, case by case, is critical and resource intensive. A robust tracking tool is key to tracking and reporting RAC activity. At The New York-Presbyterian Hospital, Patient Financial Services uses the Greater New York Hospital Association's tracking tool. For more information on the tracking tool you may contact Stewart Presser at presser@gnyha.org / 212-506-5444.
  - Patient Financial Services is an important participant in this process for:
    - Account reconciliation – RAC cases have been processed and paid by Medicare. Medicare take-backs affect A/R balances including co-insurance and deductible amounts and
    - Submission of adjustment claims to secondary carriers when required.
  - All RAC activity is time-sensitive. Missing deadlines has serious financial implications.

- **Communication**
  - Schedule routine conference calls with the RAC Team to discuss cases and strategies.
- **"Don't be surprised"**
  - Review charts and other medical documentation prior to or upon submission to the RAC. Try to assess what the RAC is looking for – DRG coding, medical necessity of setting, documentation of services billed, etc.

NYS PEPPER DATA – 2Q 2007

Short-Term, Acute-Care PEPPER
183 New York PPS Hospitals for
1-Day Stay Top 20 DRGs

Statewide Top 20 DRGs for One-Day Stay Discharges* for FY2007 through Q2
In Descending Order by One-Day Stay Totals Per DRG

DRG	Description	One-Day Stay Count	Total Dis-charges for DRG	Proportion of One-Day Stays to Total Dis-charges for DRG	Statewide Average Length of Stay for DRG
558	Percutaneous cardiovascular proc w drug-eluting stent w/o maj cv dx	3,246	4,310	75.3%	1.6
143	Chest pain	3,211	8,161	39.3%	2.4
127	Heart failure & shock	897	18,758	4.8%	6.2
182	Esophagitis, gastroent & misc digest disorders age >17 w CC	848	8,039	10.5%	4.7
141	Syncope & collapse w CC	846	5,550	15.2%	4.0
515	Cardiac defibrillator implant w/o cardiac cath	772	1,592	48.5%	4.5
125	Circulatory disorders except AMI, w card cath w/o complex diag	737	1,759	41.9%	2.7
142	Syncope & collapse w/o CC	735	2,623	28.0%	2.8
138	Cardiac arrhythmia & conduction disorders w CC	700	6,005	11.7%	4.9
139	Cardiac arrhythmia & conduction disorders w/o CC	682	2,278	29.9%	2.8
557	Percutaneous cardiovascular proc w drug-eluting stent w major cv dx	664	2,210	30.0%	3.8
556	Percutaneous cardiovasc proc w non-drug-eluting stent w/o maj cv dx	662	969	68.3%	1.9
552	Other permanent cardiac pacemaker implant w/o major cv dx	643	2,123	30.3%	4.2
395	Red blood cell disorders age >17	613	3,756	16.3%	4.9
183	Esophagitis, gastroent & misc digest disorders age >17 w/o CC	601	2,743	21.9%	3.2
088	Chronic obstructive pulmonary disease	591	10,953	5.4%	5.6
534	Extracranial procedures w/o CC	560	780	71.8%	1.7
296	Nutritional & misc metabolic disorders age >17 w CC	553	6,923	8.0%	5.8
524	Transient ischemia	503	3,572	14.1%	3.8
294	Diabetes age >35	491	4,040	12.2%	5.1
Top 20 DRGs Statewide		18,555	97,144	19.1%	4.5
All DRGs Statewide		39,726	344,580	11.5%	6.7

*Excludes deaths, transfers, and leaves against medical advice.

Note that some DRGs changed for FY 2007. The User's Guide cites source for more detailed information.

FL PEPPER DATA – 2Q 2007

Short-Term FATHOM 19 Report
177 Florida PPS Hospitals for
1-Day Stay Top 20 DRGs

Statewide Top 20 DRGs for One-Day Stay Discharges* for FY2007 through Q2
In Descending Order by One-Day Stay Totals Per DRG

DRG	Description	One-Day Stay Count	Total Dis-charges for DRG	Proportion of One-Day Stays to Total Dis-charges for DRG	Statewide Average Length of Stay for DRG
558	Percutaneous cardiovascular proc w drug-eluting stent w/o maj cv dx	3509	5663	62%	1.9
143	Chest pain	3107	8376	37%	2.2
138	Cardiac arrhythmia & conduction disorders w CC	1254	8075	16%	3.8
127	Heart failure & shock	1244	22259	6%	5.2
182	Esophagitis, gastroent & misc digest disorders age >17 w CC	1128	9454	12%	4.0
125	Circulatory disorders except AMI, w card cath w/o complex diag	1066	3469	31%	2.8
552	Other permanent cardiac pacemaker implant w/o major cv dx	1008	3267	31%	3.5
515	Cardiac defibrillator implant w/o cardiac cath	931	2206	42%	4.2
534	Extracranial procedures w/o CC	895	1349	66%	1.7
141	Syncope & collapse w CC	839	5617	15%	3.4
524	Transient ischemia	822	4778	17%	3.1
500	Back & neck procedures except spinal fusion w/o CC	818	1578	52%	2.0
139	Cardiac arrhythmia & conduction disorders w/o CC	810	2567	32%	2.4
088	Chronic obstructive pulmonary disease	802	14671	5%	5.1
395	Red blood cell disorders age >17	766	4225	18%	4.2
557	Percutaneous cardiovascular proc w drug-eluting stent w major cv dx	729	3861	19%	4.3
556	Percutaneous cardiovasc proc w non-drug-eluting stent w/o maj cv dx	694	1165	60%	2.0
533	Extracranial procedures w CC	637	1640	39%	3.7
132	Atherosclerosis w CC	625	2474	25%	2.9
296	Nutritional & misc metabolic disorders age >17 w CC	618	6407	10%	4.5
Top 20 DRGs Statewide		22,302	113,101	19.7%	3.9
All DRGs Statewide		49,980	412,837	12.1%	5.5

*Excludes deaths, transfers, and leaves against medical advice.

Note that some DRGs changed for FY 2007. The User's Guide cites source for more detailed information.

CA PEPPER DATA – 2Q 2007

Short-Term FATHOM 19 Report
319 California PPS Hospitals for
1-Day Stay Top 20 DRGs

Statewide Top 20 DRGs for One-Day Stay Discharges* for FY2007 through Q2
In Descending Order by One-Day Stay Totals Per DRG

DRG	Description	One-Day Stay Count	Total Dis-charges for DRG	Proportion of One-Day Stays to Total Dis-charges for DRG	Statewide Average Length of Stay for DRG
558	Percutaneous cardiovascular proc w drug-eluting stent w/o maj c	2942	4243	69%	1.7
143	Chest pain	2735	7206	38%	2.2
127	Heart failure & shock	1265	19497	6%	5.1
182	Esophagitis, gastroent & misc digest disorders age >17 w CC	976	7476	13%	4.1
138	Cardiac arrhythmia & conduction disorders w CC	957	5493	17%	3.7
552	Other permanent cardiac pacemaker implant w/o major cv dx	839	2386	35%	3.2
296	Nutritional & misc metabolic disorders age >17 w CC	829	7508	11%	4.3
557	Percutaneous cardiovascular proc w drug-eluting stent w major c	753	3028	25%	4.0
141	Syncope & collapse w CC	745	3719	20%	3.2
500	Back & neck procedures except spinal fusion w/o CC	732	1632	45%	2.1
524	Transient ischemia	703	3099	23%	2.9
515	Cardiac defibrillator implant w/o cardiac cath	702	1397	50%	3.9
088	Chronic obstructive pulmonary disease	662	10796	6%	4.8
395	Red blood cell disorders age >17	658	3323	20%	3.9
125	Circulatory disorders except AMI, w card cath w/o complex diag	640	1889	34%	2.7
534	Extracranial procedures w/o CC	632	944	67%	1.6
089	Simple pneumonia & pleurisy age > 17 w CC	631	17016	4%	5.4
139	Cardiac arrhythmia & conduction disorders w/o CC	622	1708	36%	2.3
518	Percuataneous cardiovascular proc w/o coronary atery stent or AI	615	931	66%	2
554	Other vascular procedures w CC w/o major cv dx	607	2467	25%	5.2
Top 20 DRGs Statewide		19,245	105,758	18.2%	4.1
All DRGs Statewide		45,566	374,604	12.2%	5.5

*Excludes deaths, transfers, and leaves against medical advice.

Note that some DRGs changed for FY 2007. The User's Guide cites source for more detailed information.

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