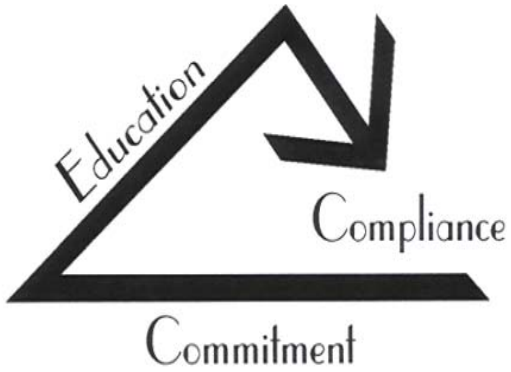
What's New with RAC?
Audit findings, Updates, & Operational Ideas

Fourth Medicare RAC Summit

September 14, 2010

Day Egusquiza, President

AR Systems, Inc



Outline of Training

- **<u>GOAL OF RAC AUDITS</u>: To ensure all billable services (UB, 1500, other billing forms) are accurately reflected in the medical record.**
- **Common issues:**
  - **Dept staff not understanding the charge capture must match physician order and documentation.**
  - **Lack of ongoing coder education**
  - **Lack of ongoing dept head ed**
  - **Lack of physician understanding**

GAO finds CMS still sputtering

- Govt accounting office issued a report (March 2010) that indicated "CMS failed to act on RAC findings results in $231 M loss."
- CMS did not actually take steps to correct the vulnerabilities the program uncovered.
- 5 years after the launch of the demo RAC, CMS has yet to implement corrective measures, let alone appt someone to oversee the process.
- CMS has taken steps to resolve it's own coordination issues with the permanent RACs, but 60% of the most significant issues uncovered by the RAC have been ignored.
- **GAO recommended**: a) develop criteria to develop adequate measures to reduce future improper payments; b) identify and prevent future Medicare fee for service thru high level direction within CMS and c) assess the effectiveness of the corrective action plan for reducing future improper payments.

CMS series w/ MedLearn

www.cms.gov/RAC

- SE1024 “RAC: High Risk Vulnerabilities- No documentation or insufficient documentation submitted”
- Two areas of high risk were identified from the demonstration project:

  No reply to request/timely submission (1 additional attempt must be made prior to denial)

  Incomplete or insufficient documentation to support billable services

More on CMS MedLearn

- “For a Medicare claim to be paid, there must be sufficient documentation in the provider’s records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. “ (SE1024)

Patient Protection and Affordable Care Act, March 23, 2010

- Focusing on curbing fraud, waste and abuse in the Medicare program.
- Time period for filing Medicare FFS claims in Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.
- Under the new law, claims for services furnished on or after Jan 1, 2010 must be filed within 1 calendar year after date of service. In addition, mandates that claims for services furnished before Jan 1, 2010 must be filed no later than Dec 31, 2010.
- The following rules apply to claims with dates of service prior to Jan 1, 2010: claims with dates of service before Oct 1, 2009 must follow the pre-PPACA timely filing rules. Claims with dates of service Oct 1-Dec 31, 2009 must be submitted by Dec 31, 2010.
- Impact on denied claims with rebill potential with the RAC and MIC?

O'Connor Hospital Medicare Appeal Council Decision

- Many issues involving the ability to bill for OBS when an inpt is denied as incorrect setting, BUT the care was medically appropriate.
- Currently, there is no ability to bill for OBS hrs or other related outpt services such as drug administration as the revenue codes are excluded from the Part A on a Part B rebill.
- However, the ALJ hearing the O'Connor case issues a 'partially favorable decision' regarding the ability to rebill OBS.
- The ALJ found that the "observation and underlying care was warranted."
- CMS referred the case to the 4th level of appeal asserting that the ALJ erred as a matter of law by ordering Medicare payment for the observation and underlying care provided to the beneficiary because those services are not separately billable under Part A."
- The Medicare Appeals Council "does not agree that the case contains error of law."
- CMS officials have no comment on the O'Connor decision, but do tell FierceHealthFinance that 'at this time, CMS does not expect to change the current rebilling requirements."

Transmittal updates

- Transmittal 659/CR 6870. "Reporting of recoupment for overpayment on the remittance advice/RA"
  - Effective date 7-1-10
  - CMS acknowledges that the current HIPAA 835 RA does not properly at both the claim and provider level to meet the requirements of Section 935 of MMA 2003.
  - MM6870 describes the manner in which CMS will now record RAC overpayments.
  - Step 1: Records the reversal and correction to report the new payment and negate the original payment at the claim. Actual recoupment of funds does not occur at this step.
  - Step 2: Reports the actual recoupment at the provider level of the 835. There is no entry at the claim level.
  - More detail will be added to the remittance:
    - Step 2: PLB reason code (FB) forward balance. Demand letter is also sent at this time.
    - Step 2: PLB reason code (WO) overpayment recovery.

    http://cms.gov/transmittals/downloads/R6590TN.pdf

Messages from Providers

- Document your waste. Recouped for charging 60 U when only 50 was documented. Used single use vial, but no wastage was documented.
- Do not use default CPT codes. 99218/initial day OBS has a MUE of 1. However, some hospitals are using for OBS hrs in FL 44. If not required to use G code, leave blank.

Messages from Providers

- Closely watch the RAC's portal. Historical information disappears! Monitor receipt of records/completeness of records.
- Discussion period has no mandated response time from the RAC. Do not wait to start appeal activity while you are waiting for the RAC to reply/defend their position.
- Rebill when possible but assess appeal process to get MUEs errors repaid on denied claim.

CMS updates 4-10

- Q: Can the RAC do a medical necessity review on a claim that they originally reviewed for DRG validation?
- A: *At this time, if the RAC has already requested documentation and issued a review results letter to a provider for a DRG validation, the RAC will NOT be allowed to re-review the claim again for medical necessity. However, if both issues are approved (DRG validation and medical necessity) prior to the request of the additional documentation, the RAC MAY conduct both reviews simultaneously*.

- Per FHA/Kathy Reep; CMS communication: Once a claim is closed for a specific review reason, can the account be reviewed for future issues? Ex: record used for DRG, kept & reviewed at a later date for medical necessity or other approved issues?
- A: *The RAC cannot request medical records from a provider on a specific claim more than once. Additionally, at this point, the claim file cannot be held and looked at for additional issues in the future. Using the example cited above, if there are no findings on the claim, a review results letter will be sent indicating the result of the review and the claim will be closed. This may change at some point in the future*.

More updates

- Connolly , CDI and HDI – Posted June/July 2010
- New issue: Inpt Admissions without a Physician's Inpt Admit Order.
- Description: Admissions to the inpt setting require a physician's order in order to qualify and be paid as an inpt stay.
- Inpt hospital 10-01-07 open
- Reference information to support is posted

Only physician's can ….

- …direct pt care …thru
- Determining correct status
- Clarifying order of the status
  - Examples of weak orders: Admit to Dr Joe, Admit to tele, admit to medical floor, admit to 23:59, admit to medical service, admit to FIT. More clarity : Admit to inpt status and why
- Directing the clinical team as to the intensity of services that need provided when the pt 'hits the bed' as well as thru the course of treatment.
- OBS = not sure of course of treatment
  - Examples of weak order: Admit to 23 hr stay; admit to floor

RAC HealthDataInsights licenses Milliman Care guidelines

- "HDI has signed a 5 year license with Milliman Care Guidelines. HCI will use the care guidelines content and software to review Medicare claims.
- HDI will use the annually updated evidence based care guidelines products.
- The Care Guidelines promote healthcare quality by providing clinical guidelines based on the best available clinical evidence."
- CMS does not mandate or endorse any specific guidelines or criteria for utilization review."

Feb 25, 2009 "Evidence-based care guidelines will be used to combat waste in Medicare program."

Medicare's Inpt definition

Medicare benefit policy manual chpt 1 10

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

  "However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

  – The severity of the signs and symptoms exhibited by the patient;
- – The **medical predictability of something adverse happening to the patient…"**

1 day stays

- Variance rate: 40%
- Common findings:
  - UR/physician dialogue may indicate inpt, but the documentation in the admission order (or subsequent physician documentation) is not sufficient to address the severity of the pt's condition for today's condition that warrants an inpt acute level of care.
  - "Meets or doesn't meet Interqual" does not make an inpt. Medicare's definition is not well known.
  - Weakness in EMRs that do not address the 'uniqueness' of the pt's care and intensity of the service that is being performed. (Nursing documentation- no narrative to support electronic-no ability to expand on the uniqueness of the pt's story.)

More 1 day challenges

- Problematic diagnoses and other risk areas:
  - Rule out – anything! If a physician is not clear as to the reason for admit/undetermined dx or course of treatment, place in OBS, aggressively work up the pt and rule in= inpt; rule out= discharge safely. (Exceptions do exist)
  - Using a non-treating physician to confirm inpt status does not replace or supplement the attending/treating physician's documentation.
  - Conversations to support "admitting to inpt" is rarely actually documented in the record.
  - H&Ps and D/C summaries are not consistently present.

Observation is not a mini-inpt

- Definite misunderstanding of what OBS is.
- Viewed as a time frame rather than a pt's condition. (Miracle 23 hr cures = discharge or Monday am quarterbacking to 'fix weekend.")
- Billable hrs vs hrs in a bed
- Audit three types of OBS:
  - ER to OBS – saw provider onsite
  - Post procedure to recovery to OBS
  - Direct from a provider or SNF to a bed

3 Day SNF qualifying stay

- Variance rate two fold:
  - To be an inpt 40%
  - To remain an inpt 60%
- Audit focus:
  - Medically appropriate to be an inpt
  - Medically appropriate to remain an inpt for all 3 days.
  - Severity of illness/1st day; intensity of service/all 3 days.

Medical Necessity has started

CGI - Modified 11 to include Medical necessity Aug 2010	Medical Necessity, Inpt accuracy of order & MS –DRG validation (MN and MS-DRG validation)
Kidney & Urinary Tract infections w/MCC MS-DRG 689	Heart failure & shock W/MCC , w/CC and w/o CC MS-DRG 291, 292, 293
Musculoskeletal Disorders MS DRG 551, 552	Nutritional and Metabolic Disorders MS-DRG 249
Nervous System Disorders MS DRG 056, 057, 069 Respiratory MS DRG 192	Percutaneous Cardiovascular Procedures MS DRG 249
Cardiac Arrhythmia & conduction disorders W/MCC or W/CC DRG 138, MS DRG 308	Chronic Obstructive Pulmonary Disease, DRG 88,MS DRG 190, 191
Esophagitis, gastro & misc digestive disorders w/MCC DRG 182, MS DRG 391	Renal Failure MS DRG 682, 683, 684

Ill hospital example/CGI

- Addition documentation letter received read:
- *"Good Cause for Issue: Chronic Obstructive Pulmonary Disease DRG 88 MS-DRG 190, 191 (Medical Necessity Review and MS-DRG Validation). During the course of the DRG validation, the RAC will also review the record for inpt admission order.*
- *The documentation is being requested because COPD is one of CMS's top volume DRGs. Therefore, DRG 88, currently MS-DRG 190 and 191 was selected to determine if the principle and secondary diagnoses were assigned inappropriately resulting in overpayments to the hospitals. An analysis of your billing data indicates that a potential aberrant billing practice may exist for these MS-DRGs."*

Ill Hospital Makes It Real/CGI

- 1st MN request, 90 records, DX listed below for the 6 MN new issues
- Had DRG, MN and inpt accuracy listed on all

COPD	Cardiac Arrhythmia	Excisional debridement	Heart failure and shock
Renal failure	Extensive OR procedure unrelated to principal Dx	Disease/disorder of the respiratory system	Kidney & UTI
Espohagitis/ gastronenteritis	Aneurysm repair	Coronary bypass w/PTCA	Tracheostomy
Perc Cardiovasc procedures w/stent	GI Disorders	Other circulatory system dx	Other vascular dx
Syncope and collapse	Red blood cell disorders	Atherosclerosis with MCC	Nervous system disorders

Medical Necessity for HDI

HDI – Ten MN audits Aug, 2010	Medical necessity, inpt accuracy, DRG Validation
Cardiovascular, other MS DRG 312 (MN and DRG validation)	Musculoskeletal disorders (MS DRGs 551 and 552)
Blood and immunological orders MS DRG 811 (MN and DRG validation)	Cardiovascular diseases MS DRG 253, 254, 291-93, 302, 308, 313-316 (MN and DRG validation)
Nervous system disorders MS DRG 056, 057, 069 (MN and DRG validation)	Kidney & urinary tract disorders MS DRG 682-684, 689 (MN and DRG validation)
Endocrine, nutritional and metabolic disorders MS DRG 640 (MN and DRG validation)	Gastrointestinal disorders MS DRG 391, 393 (MN and DRG validation)
MDC 04 Respiratory MS DRG 190, 191, 192 (MN and DRG validation)	Cardiac procedures MS DRG 249 (MN and DRG validation)

Connolly – Drug dosages /multiplier issues

- June, 2010 Connolly posted new issues relative to drug /J code accuracy. Tying the J code and the units/multiplier on the UB.
- Paclitaxel
- Cetuximab
- Paclitaxel protein –bound particles
- Tenectplase
- Pamidronate disodium
- Adenosine
- Zoledronic acid (reclast) 1 mg

Medical Necessity for Connolly

HDI – Seven MN audits Aug 29, 2010	Medical necessity, inpt accuracy, DRG Validation
Other Vascular Procedures, MS DRG 253,254	Chest Pain, MS DRG 313
Heart Failure & Shock, MS DRG 291, 292, 293	Nutritional and Misc Metabolic Disorders, MS DRG 640
Circulatory System Disorders, MS DRG 314, 315, 316	Atherosclerosis, MS DRG 302
Cardiac Arrhythmia, MS DRG308	

Language with Connolly's Notice

- "RAC will review documentation to validate the medical necessity of short stay, uncomplicated admissions of MS DRG (XXX). Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly."

  "RACs will also review documentation for DRG Validation requiring that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRG, principal diagnosis, secondary diagnoses and procedures affecting or potential affecting the DRG." (Aug 2010)

Contact Info for RACs (11-09)

- New issues will be posted, RAC specific
- There is a CMS rep assigned to each RAC

- Region A-DCS Info@dcsrac.com 866 201 0580
- Region B-CGI RACB@cgi.com 877 316 7222
- Region C-Connolly www.connollyhealthcare.com/RAC; RAC info@connollyhealthcare.com 8663602507
- Region D-HDI racinfo@emailhdi.com 866590 5598

WPS Medicare Redetermination Requests

- When submitting a request for an appeal, you have different options.
- Submit in writing or via fax. When utilizing the fax, there is no need to follow up with a hard copy of the documentation.
- Submit your request only one time, utilizing only one method.
- Duplicate submissions or following up with hardcopy may delay your appeal.
- If you are bringing attention to a specific item you are faxing, please circle or indicate by asterisk, as higlights do not appear when the fax Is received.

Aug 20, 2010

To rebill or not to rebill

- If an inpt is denied and the facility determines a misunderstanding of a Medicare regulation occurred and does not appeal – the RAC team should immediately discuss the value/potential of the rebill.
  - Internal cost as manual rebill.
  - Only ancillary services can be rebilled
  - Pt had refund for inpt deductable; now will owe outpt coinsurance.
  - Perception to public
  - Real C A S H
  - Track and trend any recoupments with rebills separate from recoupments with 100% absorbed losses
  - Timeline for rebills must be followed

Revenue Codes for Part B on a Part A claim

- These revenue codes/department charges are billable on a Part B claim of a denied Part A service. 12x
- 27x/supplies; 30x/lab;32x/imaging; 331 & 335/chemo; 333/Radiation therapy; 34x/nuc med; 35x/CT; 379/anesthesia; 401/dx mammo; 402/ultrasound;403/screening mammo; 404/PET; 42x/PT; 43x/OT; 44x/ST; 46x/pulmonary; 48x/cardio, cath lab, cardiac stress test; 540-45/ambulance; 61x/MRI;634/Epo under 10,000 U; 635/Epo over 10,000 W;636/pharmacy;730-1/EKG & ECG tele;732/tele;739/EKG cardio lab;74x/EEG;77x/Vaccination adm;790/litho;920/other dx services; 921/vascular lab; 922/EMG;923/pap smear;929/invitro fertilization; 985/non-invasive physician. NO Surgery!

What will the pt impact be?

- If the inpt is denied, the pt (and Medigap supplements) will be informed they don't owe the inpt deductible. Refund to pt and/or supplement or auto recoupment.
- If the facility determines they would like to do a corrected claim submission once a decision is made not to appeal – the pt will receive notice they owe a new outpt deductible/coinsurance.
- If the outpt claim is denied payment, the pt will be informed they don't owe the outpt portion.
- HINT: Develop scripts for the PFS staff to explain.
- NOTE –all activity/recoupments can go back 3 years beginning with 10-1-07 PD dates.

Sample letter communication

- *Dear pt*
- *As part of ABC hospital's commitment to compliance, we are continuously auditing to ensure accuracy and adherence to the Medicare regulations.*
- *On (date), Medicare and ABC hospital had a dispute regarding your (type of service). Medicare has determined to take back the payment and therefore, we will be refunding your payment of $ (or indicate if the supplemental insurance will be refunded.)*
- *If you have any questions, please call our Medicare specialist, Susan Jones, at 1 -800-happy hospital. We apologize for any confusion this may have caused.*
- *Thank you for allowing ABC hospital to serve your health care needs.*

RAC FAQ update #9503

- If a provider performs a self audit, how should they notify the RAC?
- A: If a provider does a self audit and identifies improper payment, the provider should report the improper payments to the appropriate MAC, FI or carrier. The exact information necessary for the self referral can be determined by contacting your Medicare claims processing contractor.
- There are two types of self audits: 1) Commonly called a voluntary refund and is claim based. If the required claim information is included along with the amt of the improper payment, the claim will be adjusted. The RAC will be aware of the adjustment, but the refund does not preclude future review. 2) Involves extrapolation. If extrapolation is used, the claim processing contractor will review the case file to determine if it is acceptable. The MAC can accept or deny the extrapolation for the issue identified by the provider. If the claim MAC accepts the extrapolation, these claims will be excluded from the RAC review.

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Thanks for joining us!