


# RAC SUMMIT

## March 2011


At Risk Issues  
Small and Critical Access Hospitals



# Focus on standardizing charge capture

- ▶ Regardless of whether you are in a small hospital or a critical access hospital – all charge capture rules are the same as the bigger hospitals.
  - ▶ THINK BIG
  - ▶ All size hospitals are subject to audit...
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# Critical Access Hospitals

- ▶ Ensure the edits are turned on –same as non-CAHs.
  - ▶ CAHs are not paid outpt OPPS which is driven by FL 44 /UB.
  - ▶ Regardless of the payment methodology, the CAHs must process their claims with the same edits –working off FL 44.
  - ▶ Ensure the MAC/FI has the CAH edits the same as non-CAH .
  - ▶ Ensure the claim's scrubber uses the same edits –regardless of the size of the hospital.
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# Edit Errors Example

- ▶ CAH are being able to submit 2 initial 1<sup>st</sup> hrs of drug administration. Both are paid with no consideration for the edit to require a modifier.
- ▶ Small hospital billed and was paid for multiple RT CPT for 'demo and eval.' Only 1 should be allowed.
- ▶ 59 modifier – ensure there is an excellent understanding of when to use the 59 and the use of the CCI edits. (Hint: If no edits are requiring a 59, then it is likely they are not turned on)

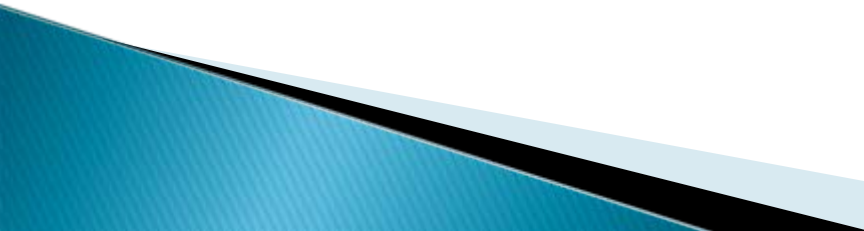
# Provider Challenges

- ▶ Employed provider may be the worst documenter! May also be the most challenging to 'hear the opportunity' for improvement.
  - ▶ Recruitment for providers is a huge issue.
  - ▶ Ensure documentation supports billed services, and yet – what other provider is there to use?
  - ▶ Must do ongoing education – including joint auditing to identify weaknesses.
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# Multiple hats worn by leaders

- ▶ Charge capture and documentation leaders may also be the actual care givers.
  - ▶ Working dept heads have difficulty allocating time to do ongoing auditing for accuracy with education to staff on 'ownership'.
  - ▶ Difficult but regardless of the size of the hospital, ongoing commitment to accuracy with documentation to support billable services must occur.
  - ▶ "I am so busy taking care of pts, you can't expect me to know all this money stuff!"
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# Transfer to Swing and SNF

- ▶ A 3 day clinically appropriate day stay must occur prior to transferring to a Swing bed and/or SNF.
  - ▶ Statement of work indicates that no 'innocent party' can be harmed.
  - ▶ However, if the facility is referred to their owned swing bed and/or SNF –the innocent party ?
  - ▶ No ruling yet from CMS on the non-innocent party recoupment– both 3 day and post care
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# New CMS/RAC FAQ Updates

#ID 10007 4/13/2010 updated on  
11/2/2010

- ▶ "Can the RAC do a medical necessity review on a claim that they originally reviewed for DRG validation?"
- ▶ A: Beginning Nov 1, 2010, if the RAC has already requested documentation and issued a review results letter to the provider for a DRG validation, the RAC will 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 also conduct both reviews simultaneously. Each additional documentation request (ADR) is subject to the same review timeframes and counts toward the provider's ADR limit.



# Another FAQ

#ID10239 11/2/10

- ▶ "Can a RAC review a claim more than once?"
- ▶ A: The RAC can review a claim either through automated or complex review more than once. The exact claim line cannot be reviewed more than once but the RAC may review different claim lines in separate reviews. In addition, the RAC may conduct a DRG validation review and then separately request documentation to complete a medical necessity review.

# Complex reviews – CAHs

- ▶ Get comfortable with DRG listing as this is how the RACs are identifying the medically necessary setting
- ▶ Review the listing of focus items for complex reviews – as two components will apply:
  - Inpt order
  - Medically necessary ‘setting’  
(Documentation to support billed service)

# Messages from Providers

## Critical Access Hospital/HDI


- ▶ 19 inpts ADRs in 6 week period
- ▶ All 1 day or very short stay on inpt surgeries

Acute appy- day	CVA/TIA- 1 day	Hypokalemia/ Acute Renal failure - 2 days	Total shoulder - 1 day
Hypotensive Pt/readmit	GI bleed- 2 days	Below knee amputation-1 day	Breast Reduction- 1 day
Carbon monoxide- 1	Pneumonia-2 days	Seizures/PNA -expired-1 day	Hemo cath placement- 1
Total knee replacements - 2 days	Obstructive hepatitis-	Non-union malleolus (surgery) -1	Pancytopenia - 1 day (?comfort

# All size hospitals are impacted

- ▶ Rural Critical Access hospital. Avg Census 2
- ▶ HDI “short stay change notification”. “After our review, it is our determination that the claims listed should have been outpt OBS vs inpt.” 8-18-10
- ▶ Direct admit from a clinic. HDI findings:
  - ▶ *Pt chief complaint was hypoxia. Pt presented to ED for acute bronchitis, severe COPD – admitted as inpt. Past medical hx and pre-existing conditions stable. Medical records did not document pre-existing medical conditions or extenuating circumstances that make acute inpt admission medically necessary. Med record document services that could be provided as an outpt service.*

# Golden Rule for Audit

- ▶ Is there an order to support the billed service?
  - ▶ Does the order match the documentation in the record?  
Does the order match the documentation that matches the UB CPT code?
  - ▶ Each dept head should conduct at least quarterly audits of 10 –20 records and look for variances.
  - ▶ If identified, immediately implement a corrective action plan – involve compliance!
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# Payment recoupment impact

June 26, 2009 / CMS Website

- ▶ CMS reversed earlier decision to AUTO recoupment SNF payment if the hospital is denied/recouped its 3 day qualifying stay.
- ▶ If the hospital is recouped for any activity, Part B/physician will be evaluated, but not auto recouped.
- ▶ Will look but not auto recoup in both.
- ▶ Employed providers – recoupment is from the hospital. Contract language =shared risk.

# AR Systems' Contact Info

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Thanks for joining us!  
Free info line available.