

Hospital Collaboration with Physician Practices

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Hospital Key Recommendations

The significant problems we face cannot be solved at the same level of thinking we were at when we created them. ~ Albert Einstein

Appoint Physician Liaison

- Clinical Background
- Financial Understanding
- Politically Savvy
- Communicate Effectively

EDUCATE • EMPOWER • SUCCEED

Educate Beyond RAC

- Admission Criteria
- Medical Necessity
- CPT Coding
- ICD10
- RAC

EDUCATE • EDUCATE • EDUCATE

Establish Feedback

- Create Financial Impact Reports
 - Breakdown by Physician, Specialty & CPT
- Clinical Review/Education Meetings
 - Quarterly Surgeon Meetings
 - Monthly Specialty Surgeon Meetings
- Involve Everyone in Denial Reviews
- Establish ONE ON ONE Education
 - **The** Most Important Step for Success

Physician Facts

- 1-2 Physician Practices Comprise Over 80% of Office-Based Practices in the U.S. ¹
- Finances Not Available or Budgeted for Regular Audits by Qualified Medical Coders
- Embezzlement an Issue in Many Offices
- Future, if Cannot Manage Changes
 - Employed by Hospitals
 - Join Larger Group

¹. Hing E, Burt CW. Office-based medical practices: Methods and estimates from the National Ambulatory Medical Care Survey Advance data from vital and health statistics; no 383. Hyattsville, MD: National Center for Health Statistics. 2007.

Electronic Health Records

- Be flexible on the format you receive data for admissions; allow practices to build automated admission documents
- Work with practices to set up templates in their EHR systems for hospital services that include medical necessity coding

RAC Audit Example #1

- Patient seen for simple laceration repair to face after a fall
- Patient also presented with knee pain and wrist pain
- Billed:

99283

719.43 Wrist pain

719.46 Knee pain

12011

873.40 Open Wound of Face

- RAC requested monies back because E/M visit & procedure billed on same day
- Patient did not just seen for repair, they fell & had other issues
- If RAC would have done data mining to diagnosis level this should not even show in report to request monies back

RAC Audit Example #2

- Patient presented Emergency Department after a fall
- Billed fracture care with a “54” modifier on 4/10/11
25600-54 813.42 Distal Radius Fracture (Initial Care Only)
- Patient returned to emergency department on 6/15/11; she presented with shortness of breath and nausea
- We billed:
99284 787.01 Nausea
93010 786.05 Shortness of Breath
- RAC requested monies back because we billed a visit within a global period
- Argument: Diagnosis had nothing to do with the visit on 4/10 and by using the “54” modifier we were telling Medicare we were only handling the initial care, not follow up care

RAC Audit Example #3

- Patient presented to office for incision and drainage of abscess on leg
- The patient's appointment was for this service
- Billed:

10061	682.6	Abscess of leg
99212-25	682.6	Abscess of leg
- RAC asked for monies back due to E/M & procedure billed on same day
- Physician had to repay because:
 - Patient came in for the service
 - Was not significant separately identifiable reason for E/M visit

RAC Recommendations

- RACs should have to data mine past modifier level
 - If you look at example #1 and #3, clearly the software should have sent the request for #3 and not #1
- RACs should have to data mine to the diagnosis level
- RACs should be able to data mine by taxonomy codes
 - This could help with unnecessary requests

NPPES Issue

- When the NPPES system was created one of the reasons was to simplify the ability to tie a physician to a Tax ID within certain dates. We received a request for recoupment on a physician that currently works under our Tax ID; however the recoupment was for another group number under a date of service the physician was not employed by us. The money will not be recouped from us, however that physicians group will most likely miss the deadline to respond because the letter was not send to the correct address.
- How does this occur when the claim is filed under a specific Tax ID, group number and date of service?
- If our letters are sent to another address and we never receive is there anything set up where our group can access those physicians' outstanding issues with our RAC?

Educate the Physician Practices

The two basic processes of education are knowing and valuing. ~Robert J. Havighurst

What Is RAC? (Recovery Audit Contractor)

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly \$38 million in underpayments returned to health care providers.

Results of RAC Demo

- RAC Demonstration thru March 2008
- \$1.03 Billion in Improper Payments
- 96% \$992.7 Million Overpayment
- 4% \$37.8 Million Underpayments
- 14% Appealed -- Only 4.6% Overturned
- 85% Overpayments from Inpatient Hospitals
- 6% IRF (Inpatient Rehabilitation Facility)
- 4% Outpatient Hospital Providers (\$52,000,000)

Top Three RAC Demo Lessons

- Claim RACs Find Large Volumes of Improper Payments
- Providers Do Not Appeal Every Overpayment Determination
- Overpayment Collections Significantly Greater Than Program Costs

RAC Findings

- Service Does Not Meet Medical Necessity
- Incorrectly Coded Services
- Failure to Submit Requested Documentation or Failure to Submit Enough Supporting Documentation
-
- Other
 - Payments on Outdated Fee Schedule
 - Duplicate Payments
 - Duplicate Claims Submission

RAC Regions

RAC	Website	E-mail	Phone Number
Region A: DCS Healthcare Services States: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI and VT	www.dcsrac.com	info@dcsrac.com	1-866-201-0580
Region B: CGI States: IL, IN, KY, MI, MN, OH and WI.	http://racb.cgi.com	racb@cgi.com	1-877-316-7222
Region C: Connolly, Inc. States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands	www.connollyhealthcare.com /RAC	RACinfo@connollyhealthcare.com	1-866-360-2507
Region D: HealthDataInsights States: AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa and Northern Marianas	http://racinfo.healthdatainsights.com	racinfo@emailhdi.com	Part A: 1-866-590-5598 Part B: 1-866-376-2319

Definitions

ALJ	Administrative Law Judge
DHS	Department of Health & Human Services
DOJ	Department of Justice
DRG	Diagnosis Related Group
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MIC	Medicaid Integrity Contractor
MSP	Medicare Secondary Payer

NCD	National Coverage Determination
OIG	Office of Inspector General
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
RAC	Recover Audit Contractor
TRHCA	Tax Relief and Health Care Act of 2006
ZPIC	Zone Program Integrity Committee

Two Audit Types

- **Automated Review**- RAC's have identified improper payments because the provider clearly billed in violation of Medicare policy
- **Complex Review** - RAC identifies a likely improper payment and request the medical records from the providers to conduct more in depth review

Medical Record Limitations

Single Practitioner	10 medical records per 45 days per NPI
Partnerships (2-5 providers)	20 medical records per 45 days per NPI
Groups (6-15 providers)	30 medical records per 45 days per NPI
Large Group (15+ Providers)	50 medical records per 45 days per NPI
Providers Who Bill 100,000 claims to Medicare	200 – 300 medical records per 45 days per NPI
Other Part B Billers (Lab, DME, Outpatient Hospital)	1% of average monthly Medicare claim lines (max 200) per 45 days per NPI

RAC Facts

- Only Can Review Previous 3 Years & Not Before October 1, 2007
- Use Proprietary Techniques to Identify Claims that Contain or Likely Contain Errors Resulting in Improper Payments
- Cannot Audit to Ensure E/M Code Level is Correct (YET!)

Physician Practice Recommendations

One must learn by doing the thing, for though you think you know it, you have no certainty until you try. ~ Aristotle

Educating Physician Practices

- Contact Local Agencies (RAC)
- Appoint RAC Representative in Practice
- Medical Coding
- Create Process in Office to Handle Correspondence
- Create Preventative Program

EDUCATE • EDUCATE • EDUCATE

Contact Local Agency

- Ensure Local RAC has Correct Correspondence Information
 - Practice Name
 - Address for Correspondence
 - Tax ID
 - NPI
- Review Your RAC Region Website for Information Your RAC is Focusing On

Appoint RAC Representative

- Responsible for All Correspondence
- Responsible for Audit Tracking
- Attend Hospital Educational Seminars
- Educate Staff on Office Policy Regarding RAC
- Educate Physicians Regarding Issues with Documentation

Medical Coding

- Medical Necessity
 - Issue for all government agencies
 - Review all CPT codes annually to educate physician and practice on local coverage determinations for Medicare and Medicaid
 - Review all medical necessity denials to determine if appeal is warranted
- Encourage Move to EHR

Medical Coding (cont)

- **Modifiers – Easy Win for RAC**
 - **24** - Unrelated E/M service by the same physician during a postoperative period
 - **25** - Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.; the E/M that resulted in a decision to perform a minor surgery
 - **57** - Used to report E/M service that resulted initial decision to perform a major surgical procedure on the day of or the day before surgery
- **Physicians cannot arbitrarily “slap” a modifier on an E/M code**
 - Must have clear, concise documentation and reasoning for E/M billed procedure

Create Correspondence Process

- Create Spreadsheet to Track
 - Dates Letters Received
 - Dates Documentation Send Back to RAC
 - Categorize Errors
 - Financial Impact
 - # of Denial Reversals
- Invoice for \$0.12 Cents Per Page Charge
 - Physician Notes Only
- Retain Copies

Create Preventative Program

- Attend Education Programs
 - Hospitals
 - Medicare & Medicaid List Serves
- Audit In-House on Quarterly Basis
- Monitor Medicare & Medicaid EOMB's and Medicaid R&S's



Region C Recovery Audit Contractor (RAC)

August 2, 2011

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained Connolly Healthcare to carry out the Recovery Audit Contracting (RAC) program in the State of Texas. The RAC program is mandated by Congress and is aimed at identifying Medicare improper payments.

This letter is to notify you that Medicare has made an overpayment to you for the amount of \$138,97. A brief description of the claims associated with this overpayment can be found on the Overpayment Report page. In order to correct this overpayment, please refund \$138,97 by 09/11/2011.

This overpayment was identified through data analysis. Data analysis showed an aberrant billing pattern inconsistent with a policy. The data analysis identifying the improper claims paid by Medicare, and the detailed explanation regarding the policy in violation can both be found on the attached spreadsheet. The results of our data analysis justified reopening your claim under §1869(b) (1) (G) of the Social Security Act and 42 CFR 405.980(a) (1). These results also serve as good cause to reopen the claim, if required by 42 CFR 405.980(b) (2).

Please make the check payable to Medicare and send it with a copy of this letter to the following address:

Part B Refunds and Appeals
3101 S. Woodlawn
Denison, TX 75020

If your local claims processing contractor offers an immediate offset option contact TrailBlazer Health Enterprises, LLC.

NOTE: If the overpayment is for services that are not medically reasonable and necessary per Medicare standards and you collected the amount of the overpayment from the beneficiary, the beneficiary has the right to request payment from Medicare. Any such indemnification will be recovered from you.

CONNOLLY
healthcare

recovery audit experts

One Crescent Drive, Suite 300/Philadelphia, PA 19112 (p) 866.366.2507 (t) 203.529.2995

www.connollyhealthcare.com/RAC/

Key Timeframes

As you review the overpayment, below is some important information and key timeframes (15, 30, 40 and 120 days) to consider.

15 Days:

- **Rebuttal Process:** Under our existing regulations 42 CFR § 405.374, providers, physicians and suppliers have 15 days from the date of this demand letter to submit a rebuttal statement. The rebuttal process provides the debtor the opportunity to submit a statement and accompanying evidence indicating why recoupment should not be initiated. The outcome of the rebuttal process could change how or if CMS will recoup. If you have reason to believe the withhold should not occur on 09/11/2011 you must notify the claim processing contractor before 08/17/2011. CMS will review your documentation. The claim processing contractor will advise you of its decision in writing within 15 days of your request. However, the rebuttal statement is not an appeal of the overpayment determination, and it will not delay/cease recoupment activities.

30 Days:

- **Repayment Plans:** Please contact us immediately if you are unable to refund the entire amount at this time so that we may determine if you are eligible for a **repayment plan**. Any CMS approved repayment plan would run from the date of this letter. Recoupment by offset (which starts on day 41) can be averted by submitting a check with your repayment plan application.
- **Interest Assessment Begins on the 31st Day:** Under Medicare law, 42 CFR 405.378, a refund is required within 30 days from the date of this letter or interest will be assessed. Interest began to accrue as of the date of this demand letter and will continue to accrue at a rate of *11.50%*. Beginning on the 31st day interest will be assessed for each full 30-day period payment is not made on time. If the entire amount is refunded before day 30 no interest will be assessed on the overpayment. *Example: An overpayment is identified for \$795.45 and a demand letter is sent on 03/01/09. The physician does not remit payment on the overpayment until 04/15/09 (45 days after the date of the initial demand letter). Therefore, on 04/01/09 interest accrues on the \$795.45 for one full 30-day period.*
- **Information for those in Bankruptcy:** If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Please contact us immediately to notify us about the bankruptcy so that we may coordinate with CMS and the Department of Justice to assure your situation is handled appropriately. Please supply the name and district under which the bankruptcy is filed if possible.

40 Days

- **Recoupments:** After 40 days Medicare will begin withholding. NOTE: The withholding of Medicare payments will apply to current and future claims until the full overpayment amount and any applicable interest has been recouped or an acceptable extended repayment request is received

How to Stop Recoupment:

Even if the overpayment and any assessed interest have not been paid in full you can stop Medicare from recouping any payments if you act quickly and decisively. Medicare will permit providers, physicians and suppliers to **stop recoupment** at several points. The first occurs if Medicare receives a valid and timely request for a redetermination within 30 days from the date of this letter. If the appeal is filed later than 30 days, we will also stop recoupment at whatever point that an appeal is received but Medicare may not refund any recoupment already taken.

Medicare will again stop recoupment if, following an unfavorable or partially favorable redetermination decision, you decide to act quickly and file a valid request for reconsideration with the Qualified Independent Contractor (QIC). The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

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RECOVERY audit experts
One Crescent Drive, Suite 300/Philadelphia, PA 19112 (p) 866.360.2507 (f) 203.529.2995
www.connollyhealthcare.com/RAC/



What are the timeframes to stop recoupment:

First Opportunity: To avoid the recoupment, the appeal request must be filed within 30 days of this letter. We request that you clearly indicate on your appeal request that this is an overpayment appeal and you are requesting a redetermination. Send your appeal request to:

Part B Refunds and Appeals
3101 S. Woodlawn
Denison, TX 75020

Second Opportunity: If the redetermination decision is 1) unfavorable Medicare can begin to recoup no earlier than the 61st day from the date of the Medicare redetermination notice (Medicare Appeal Decision Letter), or 2) if the decision is partially favorable, we can begin to recoup no earlier than the 61st day from the date of the Medicare revised overpayment Notice/Revised Demand Letter, or 3) if the appeal request was received and validated after the 60th day Medicare will stop recoupment. The address and details on how to file a request for reconsideration will be included in the redetermination decision letter.

What happens following a reconsideration by a Qualified Independent Contractor?

Following decision or dismissal by the QIC, if the debt has not been paid in full, Medicare will begin or resume recoupment whether or not you appeal to any further level.

NOTE: Even when recoupment is stopped, interest continues to accrue.

120 Days

- **Appeals Must be Filed WITHIN 120 Days:** If you disagree with the overpayment decision, you may file an appeal. You have the option to appeal all of the claims from the overpayment letter or only part of the claims in the overpayment letter. An appeal is a review performed by people independent of those who have reviewed your claim so far. There are multiple levels of appeals. The first level of appeal is called a redetermination. A redetermination must be filed within 120 days of the date you receive this letter (presume five days following date of this letter). However, if you wish to avoid recoupment from occurring and assessment of interest of this overpayment, you need to file your request for redetermination within 30 days from the date of this letter as described above.

- **Filing An Appeal:** A request for a redetermination along with a copy of this letter should be mailed to:

Part B Refunds and Appeals
3101 S. Woodlawn
Denison, TX 75020

NOTE: Interest continues to accrue throughout the appeals process.

Thank you for your cooperation and prompt attention to this overpayment. If you have any questions regarding this letter or would like to discuss the overpayment identification, please direct your inquiry to the below associate.

Sincerely,

Connolly Customer Service
866-360-2507 (Press 4)

Enclosure:

CONNOLLY healthcare
recovery audit experts
One Crescent Drive, Suite 300/Philadelphia, PA 19112 (p) 866.360.2507 (t) 203.529.2995
www.connollyhealthcare.com/RAC/



Overpayment Report

Letter Ref#: 20110802132621287-8L20209

Member Name	HIC	Claim Ref #	DOS From	DOS To	Improper Pay Amt	ARR	CMS Issue Number
			09/21/10	09/21/10	\$138.97		C003852010
Total Overpayment Amt:					\$138.97		

CMS Issue Number Description:

C003852010: Under the global surgery fee concept, physicians bill a single fee for all of their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. The global surgery fee includes payment for E&M services provided during the global surgery period. Good Cause is evidenced by data analysis that identifies errors or patterns of over-utilization on the part of a provider or supplier. This causes the contractor to believe its initial determinations for the claims of the provider or supplier were incorrect as noted in Medicare Claims Processing Manual, Chapter 20: Section 110, Chapter 6: Section 20.1.2, and Chapter 3: Section 40. According to 42 CFR §405.980(b) and (c), and §405.986, a contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists. This instruction offers clarification as to what constitutes new and material evidence, as it relates to good cause for reopening the claim(s). Justification for reopening your claim was due to improper payments found in the results of our data analysis. The global surgery fee includes payment for E&M services provided during the global surgery period.



recovery audit experts
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