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Clinical Solutions

Physician Risk and Documentation Requirements Increasing

RAC and MAC Summit

November 14, 2014

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Exclusions from Coverage – Social Security Act

Sec. 1862. [42 U.S.C. 1395y] (a)…no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

FCSO Prepayment Review

2012: First Coast Service Options (FCSO), Florida MAC, implemented **prepayment review of medical necessity for 15 DRGs:**

- Cardiovascular procedures
- Spine surgery
- Lower extremity (hip and knee) total joint replacements

FCSO Prepayment Review DRGs

MS-DRGs subject to prepayment review

- 226 -- Cardiac defibrillator implant without (w/o) cardiac catheter with (w/) major complications or comorbidities (MCC)
- 227 -- Cardiac defibrillator implant w/o cardiac catheter w/o MCC
- 242 -- Permanent cardiac pacemaker implant w/MCC
- 243 -- Permanent cardiac pacemaker implant w/CC
- 244 -- Permanent cardiac pacemaker implant w/CC or MCC
- 245 -- Automatic implantable cardiac defibrillator (AICD) generator procedures
- 247 -- Percutaneous cardiovascular procedure w/drug eluding stent w/o MCC
- 251 -- Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC (continued)

FCSO Prepayment Review DRGs

MS-DRGs subject to prepayment review (continued)

- 253 -- Other vascular procedures w/CC
- 264 -- Other circulatory system or procedures
- 287 -- Circulatory disorders except acute myocardial infarction (AMI), w/cardiac catheter w/o MCC
- 458 -- Spinal fusion except cervical w/spinal curve, malign, or 9+ fusions w/o CC
- 460 -- Spinal fusion except cervical w/o MCC
- 470 -- Major joint replacement or reattachment of lower extremity w/o MCC
- 490 -- Back and neck procedures except spinal fusion w/CC/MCC or disc device/neurostimulator

FCSO Denial of Related Services

And “effective January 1, 2012, FCSO will also perform post-payment review of the **admitting physician’s and/or surgeon’s Part B services** relating to Part A services that are denied.”

First Coast Service Options Billing News, 11/15/11

MBPM: Services related to non-covered services are not covered

"Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" *non-covered* services (e.g., cosmetic surgery, *non-covered* organ transplants, *non-covered* artificial organ implants, etc.), including services related to follow-up care and complications of *non-covered* services which require treatment during a hospital stay in which the *non-covered* service was performed, are not covered services under Medicare."

Medicare Benefit Policy Manual, Ch 16, Sec 180

Rev. 189; Issued: 06-27-14

Transmittal 541: Denial of Related Claims

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 541	Date: September 12, 2014
	Change Request 8802

SUMMARY OF CHANGES: The purpose of this CR is to allow the MACs and ZPICs the discretion to deny claims that are "related" and provide approved examples of such situations.

EFFECTIVE DATE: September 8, 2014
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: September 8, 2014

Transmittal 541

"The MAC and ZPIC have the discretion to deny other "related" claims submitted before or after the claim in question…

If documentation associated with one claim can be used to validate another claim, those claims may be considered "related." Approved examples of "related" claims that may be denied as "related" are in the following situations:…

Pub 100-08, Medicare Program Integrity Manual

Transmittal 541

Transmittal 541

- When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.
- Reserved for future approved "related" claim review situations. The MAC shall report to their BFL and COR prior to initiating denial of "related" claims situations.

Pub 100-08, Medicare Program Integrity Manual

Transmittal 541

Transmittal 541

- The MAC, Recovery Auditor, and ZPIC shall not be required to request additional documentation for the “related” claims before issuing a denial for the “related” claims.
- Contactors shall process appeals of the “related” claim(s) separately.

Pub 100-08, Medicare Program Integrity Manual, Transmittal 541

Transmittal 534 - Additional Risk Areas Not Implemented (Yet?)

Transmittal 534 (which was replaced by 541):

- Allowed denial of related claims for any procedure or operation (including outpatient procedures) denied as not medically necessary.
- Allowed recoding of inpatient services as outpatient for denied admissions.
- Will these risk areas be back in the future?

FCSO Adds Prepayment Review of Level III Hospital Visits: Oct. 21, 2014

CPT 99223 – Level III initial hospital visit

CERT error rate 39.8%

CPT 99233 – Level III subsequent hospital visit

CERT error rate 34.4%

" In response to the high percentage of error rates and the continual risks of improper payments associated with hospital care visits billed by internal medicine specialists, First Coast will be implementing a prepayment medical review audit for *CPT®* codes *99223* and *99233* billed by internal medicine specialty. The new audit will be based on a predetermined percentage of claims in an effort to reduce the error rates for these hospital services."

http://medicare.fcso.com/EM/266956.asp

NGS: MAC Prepayment Review of E&M C

E/M Services Impacted by This Review

CPT Code	CPT Descriptor
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity
99215	Office or other outpatient visit for the evaluation and management of an established of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity

https://www.google.com/?gws_rd=ssl#q=Prepayment+review+for+initial+and+subsequent+hospital+evaluation+and

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Thank you.

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