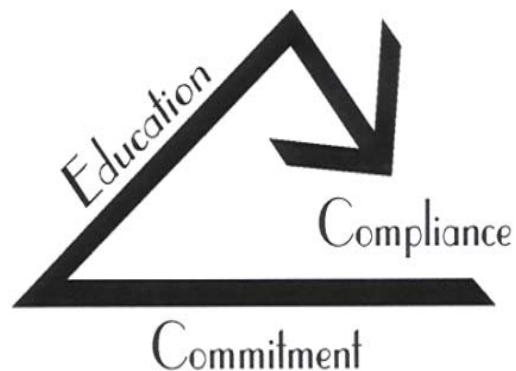


# AR Systems, Inc Training Library Presents

## Happenings and Clinical Documentation Ideas to Reduce Vulnerabilities

Instructor:

Day Egusquiza, Pres  
AR Systems, Inc



# CMS Claim's Review Entities

## Roles of Various Medicare Improper Payment Reviews

Timothy Hill, CFO , Dir of Office on Financial Mgt

9-9-08 presentation

Entity	Type of claims	How selected	Volume of claims	Purpose of review
QIO	Inpt hospital	All claims where hospital submits an adj claim for a higher DRG. Expedited coverage review requested by bene	Very small	To prevent improper payment thru <b>upcoding</b> . To resolve <b>disputes</b> between bene and hospital
CERT	All	Randomly	Small	To <b>measure</b> improper payments
MAC	All	Targeted	Depends on # of claims with improper payments	To <b>prevent</b> future improper payments
RAC	All	Targeted	Depends on the # of claims with improper payments	To <b>detect and correct past</b> improper payments
PSCZPIC	All	Targeted	Depends on the # of potential fraud claims	To identify <b>potential fraud</b>
OIG	All	Targeted	Depends on the # of potential fraud claims RAC 2012	To identify <b>Fraud</b>

# CMS Quarterly Newsletter –

\*Based on collected amts thru Sept 30, 2011

Region	Overpaymts (\$ in millions)	Underpaymt	Total 3 <sup>rd</sup> Q Corrections (Based on actual collections)	FY to Date Corrections Data Oct 2010–Sept 30, 2011)
Region A/DCS	\$ 43.3	\$ 5.8	\$ 49.1	\$146.3
Region B/CGI	\$ 60.4	\$ 3.2	\$ 63.6	\$170.3
Region C/Connolly	\$ 65.2	\$ 60.7	\$125.9	\$260.9
Region D/HDI	\$108.2	\$ 6.9	\$115.1	\$361.8
Nationwide Totals	\$277.1	\$ 76.6	\$353.7	\$939.4

# Top Issues per Region/9-2011

- ▶ Region A: Renal & Urinary Tract Disorders (medically necessary/incorrect setting)
- ▶ Region B: Surgical Cardiovascular Procedures (medically necessary)
- ▶ Region C: Acute inpt admission neurological disorders (medically necessary)
- ▶ Region D: Minor surgeries and other treatment billed as an inpt (medically necessary ) \*When pts with known dx enter a hospital for a specific minor surgical procedure and is expected to keep them less than 24 hrs, they are considered outpt regardless of the hour they present to the hospital, whether a bed was used or whether they remain after midnight.

# Change the Inpt surgery process

- ▶ Surgery director and surgery scheduler join the preventive team.
- ▶ UR reviews all inpt surgeries prior to surgery. Reviews the H&P, discusses how well the surgeon has tied in the risk to the reason for a normal outpt to be done as an inpt.
- ▶ Works with provider and Surgery to potentially revise to an outpt, wait for the adverse/unexpected event and move to obs or inpt or improve the inpt documentation.
- ▶ Involved nursing in the education as they will be the bedside eyes of the pt status.

# Only physician's can ....

- ▶ Determining correct status
- ▶ Clarifying order of the status
  - Examples of weak orders: Admit to Dr Joe, Admit to tele, Transfer to the floor, admit to 23:59, admit to medical service, admit to FIT. **None clearly define : Admit to inpt status and why -add (intent of the order)**
- ▶ 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.
- ▶ 42 CFR 482.12 (c) (2) "Patients are admitting to the hospital only on a recommendation of a licensed practitioner permitted by the state to admit pts to the hospital. "
- ▶ Medicare State Operations Manual "In no case may a non-physician make a final determination that a pt's stay is not medically necessary or appropriate." Case Mgt protocol can 'recommend' to the providers but only takes effect when the provider has authenticated it.

# If a non-attending/admitting...

- ▶ Many facilities are using outside physician advisors or are growing their own advisors – many times the UR physician.
- ▶ Ensure that any 2<sup>nd</sup> opinion by a non-treating provider is ‘validated’ and used for directing care by the attending/admitting. Otherwise it is just another non-treating opinion. Additionally, look for educational opportunities thru patterns --dx, documentation, doctor.
- ▶ Double check with the QIO for their opinion during audit.

# Concurrent auditing of 2<sup>nd</sup> opinions for pt status

- ▶ Ensure the provider receiving the 2<sup>nd</sup> opinion carries the recommendation into the record and directs care from the recommendation
- ▶ Auditing of the primary provider's documentation should include: Clearly outlining the severity of illness in the admit note/order PLUS nursing documenting to the Intensity of services that must be done as an inpt.
- ▶ Nursing is usually unaware of the status they are documenting.



# EMR Challenges

- ▶ Hybrid records present extreme challenges in identifying the skilled care/handoffs of intensity of service between the care areas.
- ▶ EMRs tend to present the patient's history in a 'cookie cutter' concept without pt specific issues.
- ▶ Treatment/outcomes/results of ordered services are often omitted from the clinical/nursing record.



# 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)

# Physician and Hospital Shared Risk – Pt Status

- ▶ Trailblazer/MAC Jurisdiction 4, 8-30-10 “Inappropriate Hospital Admission vs Outpt Observation”
- ▶ Medicare requirements that the inpt admission begins when the admission order is written. Additionally, all physician orders must have a date and a legible signature.
- ▶ Physician’s decision to treat the pt as an outpt or inpt are reflected in the physician’s orders. The pt’s condition, history and current dx test results, along with the physician’s medical judgment, availability of treatment modalities and hospital admission policies should be considered when making a decision to provide inpt level of care. If a physician determines additional information is making a medical decision for inpt admission, the physician may elect to place in OBS outpt status.

# More from Trailblazers

- ▶ Scenario 1
- ▶ An inpt claim is submitted for medical review
  - The claim is without a written and signed physician order for admission
  - The documentation is without an admit note describing the reason for admission to an inpt level of care/LOC
  - The services rendered could have been rendered in an outpt setting
  - The screening tool indicates the intensity of services and the severity of illness of the pt's condition as documented did not support the medical necessity for inpt LOC
  - Medical review decision: Denied because documentation does not support the medical necessity for an acute level of care
  - **IF THE PATIENT'S CONDITION REQUIRES INPT ADMISSION, the physician needs to document an inpt admission order with a progress note describing the medical decision for the inpt admission and the intended treatment plan to address the patient's condition.**
  - Internet Only Medicare Manual (IOM) Pub 100-04, Medicare Claims Processing Manual; chapter 1, section 50.3; chapter 3, section 40.2.2.k

# Clinical Documentation

## Improvement – go beyond CMI

- ▶ Focus resources on BOTH documentation to clarify coding requirements (with much less queries)
- ▶ AND documentation to support INPT status
- ▶ Create “pearls” of education on how easy it is to improve the documentation – per specialty.
- ▶ PS this will also help prepare facilities for ICD 10...
- ▶ Tie in the coder’s queries to track and trend documentation challenges, per provider.

# Pre-Payment Expanded Info

## Dec 2011 – Prepayment CMS calls

- ▶ Limitations on prepayment won't exceed current post payment ADR limits.
- ▶ Medical records provided on appeal will be remanded to the RAC for review
- ▶ Claims will be off limits from future post payment reviews
- ▶ ADR letter will advise where to send: RAC or MAC.
- ▶ 30 days to reply

- ▶ June 1 – 312/Syncope
- ▶ Aug 1 – 069/Transient Ischemia; 377/GI hemorrhage w/MCC
- ▶ Sept 1 – 378/GI Hemorrhage w CC; 379/GI Hemorrhage w/o CC/MCC
- ▶ Oct 1 – 637/diabetes w/MCC; 638/diabetes w/CC; 639/diabetes w/o CC/MCC

RAC @cms.hhs.gov

//go.cms.gov/cert-demos

# MACs are auditing ... w/CMS moving from 15 to 11 MACS

- ▶ ...can be the same material as the RACs.
- ▶ Ex. Az hospital had a ST MUE error. They received automated demand letters from HDI; however, they also received 'first notice' from WPS on the same issue. Per WPS, the site has 30 days from receipt of the WPS letter without interest to repay or be recouped on the 41<sup>st</sup> day with interest.
- ▶ No published items; no limits on requests, same appeal rights. Letters SOMETIMES explain..
- ▶ WPS – Prepayment 310, 313, 192, 690
- ▶ NHIC – Prepayment auditing of Chest pain, syncope and collapse, CHF.

# More MAC audits

- ▶ **Noridian**/J3 has announced Probe audits for AZ, MT, ND, SD, UT, WY
- ▶ Probe for 1 day stays, 2 day stays, 3 day stays and high dollar (w/o definition of \$)
- ▶ Noridian was awarded JF MAC on 8-22-11 Includes ID, ND, Alaska, WA, Ore, SD, MT, WY, UT and AZ. Look for more wide spread auditing. Using CERT data for more probes
- ▶ **NGS** – Mobile CMS audits/NY & Prepayment (2012) No letters with reasons.



# And more MAC auditing

## ▶ Highmark (Now Novitas Solutions)

- Probe for DRG 470/Major Joint Replacement or reattachment of lower extremity w/MCC. **Need to document end stage joint disease & failed conservative therapy. (EX: Trailblazer Transmittal ID 14362/LCD)**
- Probe for DRG 244 Permanent Cardiac Pacemaker implant w/o CC or MCC.
- NEW: 313, 392, 292 (2012)
- Msg from provider: Have been having 100% prepayment audit payment for DRG 313/chest pain for almost 2 years now. The site indicates they are being successful around 90% of time at the 3<sup>rd</sup> level appeal/ALJ but it is taking about 18 months. There does not appear to be a change with the pre-payment review even with the overturn rate. (per PA facility history 9-11)

# And more MAC

## ▶ Trailblazer/TX highlights

- Developed LCD 41-96SAB for Hydration (96360-61)
- Reviewing DRG appeals and determining patient status was incorrect. Denied entire inpt stay.
- Issued 5 DRGs that will be on **prepayment review**: 243, 246, 247, 460, 470 (Ex: Stents, pacemaker, Joint replacement hip/knee with LCD)
- 2011 - Lost MAC bid. Highmark awarded. 1/12 - Highmark 's Medicare Division , MAC J12, was sold to BC/BC of FL (BCBSF) with their subsidiary, First Coast who is a MAC J9.

# MACs are beefing up prepayment auditing –with physician impact

- ▶ Trailblazer: to increase consistency in Medicare reimbursement, effective 11–11, Trailblazer will begin cross–claim review of these services. The **related Part B service** (E&M, procedures) reported to Medicare will be evaluated for reimbursement on a post payment basis. Overpayments will be requested for services related to the inpt stay that are found to be in error.
- ▶ First Coast & HighMark/Novitas– similar 3–12 TX hospital lost 470; provider recouped

# More MAC auditing

- ▶ Palmetto, Pre Payment Auditing
- ▶ Began early 2012
- ▶ DRGs focus:
  - 871      Septicemia/Sepsis
  - 641      Misc disorders of nutrition
  - 690      Kidney / UTI
  - 470      Joint replacement

Site: CA site. Prior to Feb, 2012 – never had a pre-payment audit request. Had 12 in 1<sup>st</sup> request.

# And more MAC – AL hospital

## Cahaba – Pre–Auditing of the below DRGs. (2–12)

- ▶ 069 (Transient Ischemia)
- ▶ 191 (Chronic Obstructive Pulmonary Disease w CC)
- ▶ 195 (Simple Pneumonia & Pleurisy w/o CC/MCC)
- ▶ 247 (Percutaneous Cardiovascular Procedure w Drug–Eluting Stent w/o MCC)
- ▶ 287 (Circulatory Disorders Except AMI, w Cardiac Cath w/o MCC)
- ▶ 313 (Chest Pain)
- ▶ 392 (Esophagitis, Gastroenteritis & Misc Digestive Disorders /o MCC)
- ▶ 552 (Medical Back Problems w/o MCC)
- ▶ 641 (Nutritional & Misc Metabolic Disorders w/o MCC)
- ▶ 945 (Rehabilitation w CC/MCC)
- ▶ 470 (Joint replacement)

# The Florida Experience

MAC /FSCO Focused Probe, 2009 & 2010

Preliminary results , FHA, RAC summit 9-10

Common w/all: No Physician order for inpt

Update: 2011 /moved to pre-payment for **313, 552**

**3-12: 6 new prepayment DRGs -153, 328,357,455,473,517**

DRG	Description	2009 Error Rate	2010 Error Rate
<b>313</b>	<b>Chest pain</b>	55.16%	76.71%
<b>552</b>	<b>Medical back pain w/o MCC</b>	70.92%	71.25%
392	Gastro & misc disorders w/o MCC	49.08%	41.93%
641	Nutrition misc metabolic disorder w/o MCC	49.27%	48.43%
227	Cardiac defib w/o cath lab w/o MCC	20.65%	45.43%

# Medicaid Hot Exposure Area

- ▶ OB – protocols
- ▶ Physicians/extended must order/direct pt care, pt specific.
- ▶ Protocols are excellent clinical pathways, but the physician must order the protocol.
- ▶ EX) Pt is 26 weeks. Nursing implements protocol for under 27 weeks. Doesn't call the provider until results from first items on the protocol. Not billable. Must contact the provider to initiate protocol , then follow protocol. Billable.

# Protocols– Challenges with Fixes

- ▶ CERT audits have continued to identify weakness in the use of Protocols.
- ▶ EX) Lab urine test ordered but culture done as 2<sup>nd</sup> test due to protocol. (Noridian/Nov 2009)
- ▶ EX) Without contrast but 2<sup>nd</sup> one done with contrast based on protocols.
- ▶ Ensure the order is either updated or the initial order clearly states ‘with protocol as necessary.’
- ▶ *YEAH – how about including the protocols that are referenced in the record when submitting for audit?*



# Contact Info for RACs (9-10)

- New issues will be posted, RAC specific
- There is a CMS/project officer assigned to each RAC
- New issues are being added/some are being taken off.
  
- Region A-DCS [Info@dcsrac.com](mailto:Info@dcsrac.com) 866 201 0580
- Region B-CGI [RACB@cgi.com](mailto:RACB@cgi.com) 877 316 7222
- Region C-Connolly  
[www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC); RAC  
[info@connollyhealthcare.com](mailto:info@connollyhealthcare.com) 8663602507
- Region D-HDI [racinfo@emailhdi.com](mailto:racinfo@emailhdi.com) 866590 5598

# AR Systems' Contact Info

---

Day Egusquiza, President  
AR Systems, Inc  
Box 2521  
Twin Falls, Id 83303  
208 423 9036  
daylee1@mindspring.com



Thanks for joining us!  
Free info line available.  
Plus our training website: [www.healthcare-seminar.com](http://www.healthcare-seminar.com)