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RAC Activity with Illustrative Cases

May 30, 2012

Provide experienced physician advisor teams as a dedicated resource for Case Managers ***"…the decision to admit, retain, or discharge a patient should be made by a physician…or through a physician advisor" (HPMP Compliance Manual)***

4-27-2012
V1.1

RAC Activity:

What have they been up to?

What's next?

National RAC Program Since 1/1/2010

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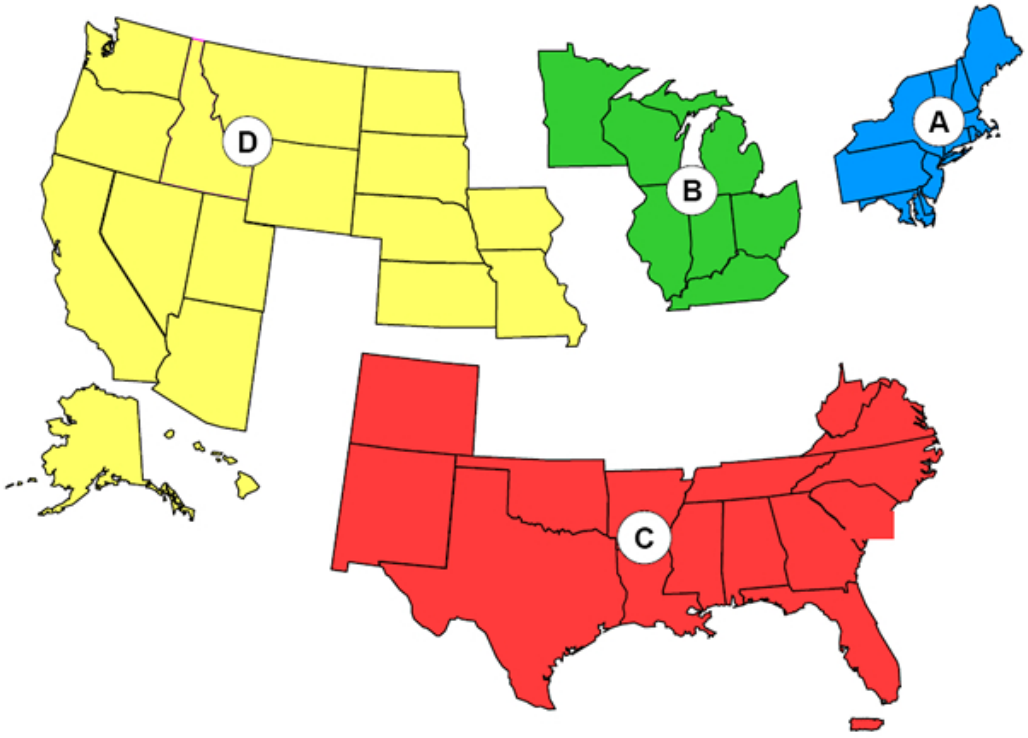
"All Gaul is divided into three parts." (Julius Caesar)

All America is divided into four parts… (CMS)



American Hospital Assoc (AHA) RACTrac (aharactrac.com)

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- 2172 hospitals have participated in RACTrac since data collection began in January of 2010.
- Nearly two-thirds of medical records reviewed by RACs **did not contain an improper payment.**
- $444 million in denied claims have been reported since the first quarter of 2010.
- The majority of complex denials are short-stay medical necessity denials.
- The majority of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary.

American Hospital Association, RACTrac, Executive Summary

RAC Denials by Reason: Q4 2011

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RAC Denials by Reason, 2nd Quarter 2011 by $$ impacted					
Region	**A**	**B**	**C**	**D**	**All**
Medically Unnecessary Admission	**71%**	**70%**	**85%**	**81%**	**78%**
Incorrect DRG or other coding error	**24%**	**26%**	**11%**	**7%**	**17%**
Other	**2%**	**3%**	**3%**	**8%**	**4%**
No or insufficient documentation	**1%**	**1%**	**1%**	**2%**	**1%**
Incorrect APC or OP billing code	**2%**			**2%**	

AHA RACTrac

Complex Denials by $$: Q4 2011

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% of Complex Denials for Lack of Medical Necessity for Admission – 4th Quarter 2011 - by $$ Impacted	
Syncope and collapse (MS-DRG 312)	21%
Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)	14%
T.I.A. (MS-DRG 69)	8%
Chest pain (MS-DRG 313)	8%
Percutaneous Cardiovascular Procedure (PCI) w non-drug-eluting stent w/o MCC (MS-DRG 249)	4%

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Underpayments Paid to Hospitals: Q4 2011

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Hospitals with Underpayments		
Region	% w under-payments	# of under-payments
Region A	76%	1,703
Region B	73%	1,850
Region C	74%	5,345
Region D	71%	4,323
National	73%	13,221

AHA RACTrac

Underpayments Paid to Hospitals: Q4 2011

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% of Hospitals with Underpayments by Reason for Underpayment	
Incorrect MS-DRG	63%
Inpatient Discharge Disposition	29%
Billing Error	7%
Outpatient Coding Error	5%
Other	11%

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RAC Appeals: Q4 2011

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	# Denials Appealed	% of denials appealed	Appeals pending	% of appeals pending	Successful appeals	% of denials overturned on appeal
Region A	37,336	41%	5,600	71%	1045	66%
Region B	25,869	38%	5,756	58%	3,374	86%
Region C	30,766	20%	6,978	78%	1,369	73%
Region D	23,118	35%	8,451	80%	772	52%
National	95,918	31%	26,785	72%	6,560	74%

AHA RACTrac

Major RAC Issues by Region

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FY 2012 Q2 (Jan– March) Major Medical Necessity Issues by Region, by $$	
Region A	**Cardiovascular procedures**
Region B	**Cardiovascular procedures**
Region C	**Cardiovascular procedures**
Region D	**Minor Surgery and Other Treatment Billed as an Inpatient Stay**

CMS Quarterly Report, Through March 31, 2012

National RAC Outcomes

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Recovery Audit National Program			
	FY 2010	FY 2011	FY 2012 Q2
Overpayments collected	$75.4 M	$797.4M	$588.4M
Underpayments returned	$16.9M	$141.9	$61.5M
% underpayments	18.3%	15.1%	9.5%

CMS Quarterly Report, Through March 31, 2012

Total Corrections by Quarter

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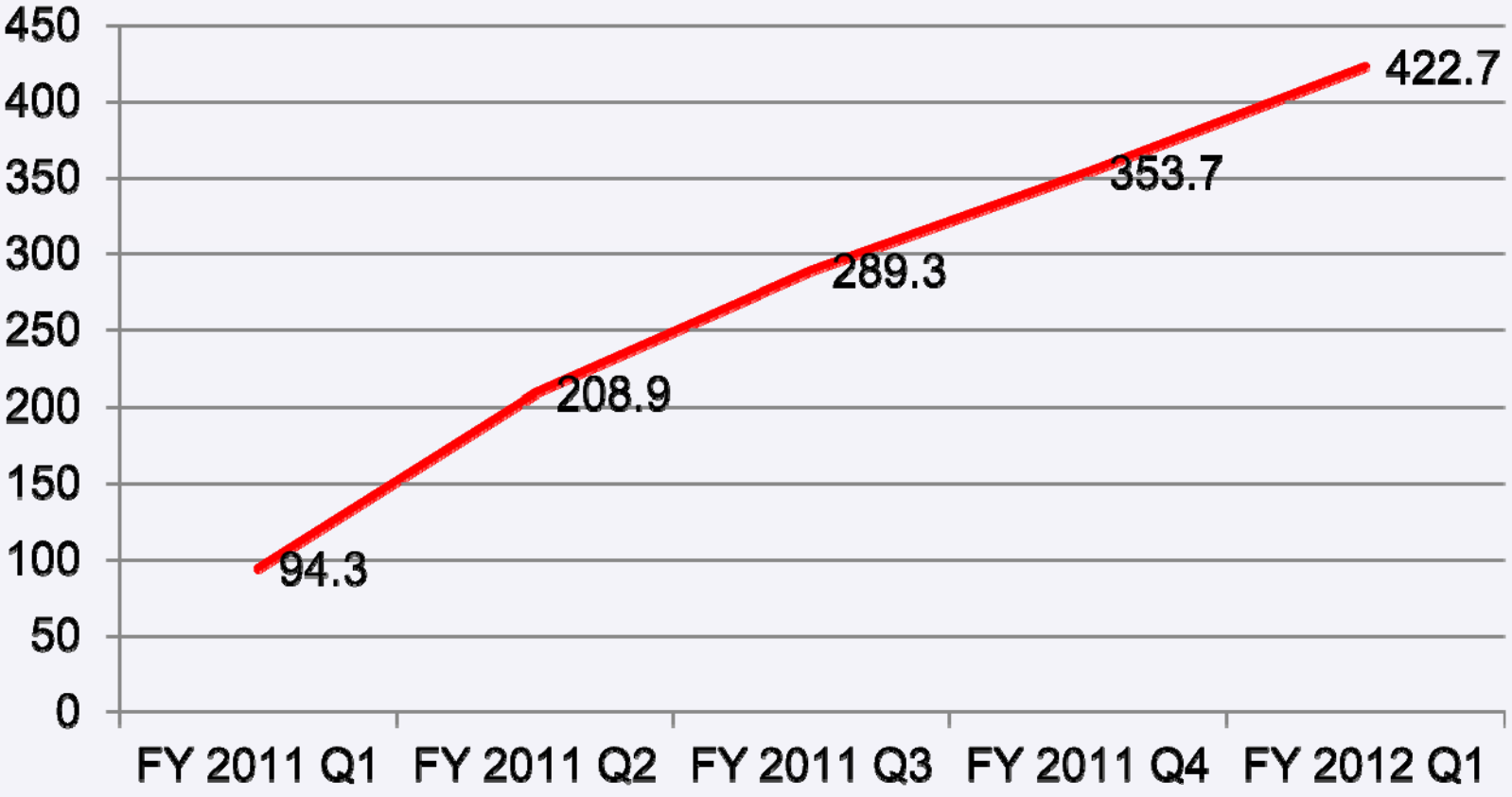
Total Corrections = Recoveries plus Repayments, in $ Millions



CMS, Feb 2012

RAC Prepayment Review

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- Scheduled to begin on or after June 1, 2012
- Eleven states: Seven states with high numbers of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high volumes of claims for short inpatient hospital stays (PA, OH, NC, MO)
- Limit on # of prepayment reviews same as current post-payment ADR limits for complex reviews

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Prepayment issues to be phased in:

- Month 1: MS-DRG 312 Syncope
- Month 3: MS-DRG 069 TIA
  MS-DRG 377 G.I. Hemorrhage w MCC
- Month 5: MS-DRG 378 G.I. Hemorrhage w CC
  MS-DRG 379 G.I. Hemorrhage w/o CC/MCC
- Month 7: MS-DRG 637 Diabetes w MCC
  MS-DRG 638 Diabetes w CC
  MS-DRG 639 Diabetes w/o CC/MCC

Inpatient Admission

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"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…"

Medicare Benefit Policy Manual – Chapter 1

Inpatient Admission

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"An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and [directly] threatening the patient's safety or health.

In many institutions there is no difference between the actual medical services provided in inpatient and outpatient observation settings; in those cases the designation still serves to assign patients to an appropriate billing category."

WPS Medicare, LCD L32222

Inpatient Surgery

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"There are procedures that, by their very nature, require inpatient care…Payment will be denied for claims that are submitted for these procedures furnished on an outpatient basis because performing these procedures on an outpatient basis was determined to be unsafe or inappropriate and therefore not reasonable and necessary under Medicare rules."

Federal Register, Sept 8, 1998, Proposed rule for OPPS

Outpatient Surgery

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"When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight."

Medicare Benefit Policy Manual, Chapter 1

	Addendum B.-OPPS Payment by HCPCS Code for CY 2011							
HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
47552	Biliary endoscopy thru skin	T	0152	31.7356	$2,185.82		$437.17	
47553	Biliary endoscopy thru skin	T	0152	31.7356	$2,185.82		$437.17	
47554	Biliary endoscopy thru skin	T	0152	31.7356	$2,185.82		$437.17	
47555	Biliary endoscopy thru skin	T	0152	31.7356	$2,185.82		$437.17	
47556	Biliary endoscopy thru skin	T	0152	31.7356	$2,185.82		$437.17	
47560	Laparoscopy w/cholangio	T	0130	38.6514	$2,662.15	$659.53	$532.43	
47561	Laparo w/cholangio/biopsy	T	0130	38.6514	$2,662.15	$659.53	$532.43	
47562	Laparoscopic cholecystectomy	T	0131	47.8453	$3,295.39	$1,001.89	$659.08	
47563	Laparo cholecystectomy/graph	T	0131	47.8453	$3,295.39	$1,001.89	$659.08	
47564	Laparo cholecystectomy/explr	T	0131	47.8453	$3,295.39	$1,001.89	$659.08	
47570	Laparo cholecystoenterostomy	C						
47579	Laparoscope proc biliary	T	0130	38.6514	$2,662.15	$659.53	$532.43	
47600	Removal of gallbladder	C						
47605	Removal of gallbladder	C						
47610	Removal of gallbladder	C						
47612	Removal of gallbladder	C						
47620	Removal of gallbladder	C						

C = Inpatient only

T = outpatient / can be inpatient Classification

APC = Ambulatory Payment Classification

No APC for inpatient procedures

Case Studies:

How proper admission status and documentation can protect you from the wrath of the RAC

Risk area: PCI

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A 68 year old man sees his internist for a routine physical. He has no cardiac symptoms. He has a history of hypertension and "borderline diabetes." His father had a heart attack at the age of 55. His physician orders a stress test. While on the treadmill, the man has some chest discomfort. His EKG shows a strain pattern and a nuclear scan shows ischemia of the lateral wall. Three days later the cardiologist performs an outpatient cardiac cath and finding a 90% blockage of the circumflex artery places a drug eluting stent. The patient is placed on a cardiac monitor and held overnight.

Inpatient, observation or routine recovery?

Risk area: PCI

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- Diagnostic cardiac catheterization is an outpatient procedure.
- When performed electively on a stable patient, PCI (stent) is an outpatient procedure.
- The patient had PCI with stent without complications.
- Routine recovery from an outpatient procedure is included in payment for the procedure; can be over night.
- Post procedure observation is used only if there are complications that require treatment or monitoring beyond usual recovery.
- Admission following outpatient procedure requires medical necessity for admission at the time of admission (serious complication)

Risk area: PCI

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When can PCI be performed as an inpatient?

- Emergent/ urgent PCI – Admit for unstable angina/ acute coronary syndrome.
- Comorbidities that increase risk of complications: Must admit before procedure and document medical necessity for performing procedure as inpatient.
- Admission for other reason prior to PCI
- Major post procedure complication: Post procedure admission → PCI is rolled into the inpatient stay under the three day rule.

Risk area: Pacemaker implant

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Case 1: A 74 year old man has been having dizzy spells and feels like he is going to pass out but has never lost consciousness. He has a history of type II diabetes controlled with oral medications and mild kidney disease. 24-hour ambulatory cardiac monitoring shows two episodes of sinus arrest lasting 3 to 4 seconds. His physician schedules him for a pacemaker. The surgery is uneventful and the patient is held over night for monitoring.

Inpatient or outpatient?

Case 2: A 68 year old woman comes to the ER complaining of dizzy spells. She is not on any medications. Her heart rate is 36 (sinus bradycardia). She is told she needs a pacemaker.

Inpatient or outpatient?

Risk area: Pacemaker implant

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- Pacemaker implantation is an outpatient procedure when performed electively on a stable patient. Recovery period may be over night.
- Case 1: Elective uncomplicated pacemaker implant with overnight (extended) recovery = **Outpatient.**
- Case 1 continued: Testing in morning shows lead malfunction = **Admit inpatient** for complication of procedure.
- Case 2: Emergency admission for sinus bradycardia (slow pulse) requiring urgent pacemaker implant = **Inpatient.** The patient is admitted because of the emergency medical condition.

Risk area: Chest pain

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A 71 year old man comes to the ER complaining of chest pain that started two days ago and has been coming and going 4 to 5 times a day without any apparent precipitating cause. Each time he feels some nausea but no shortness of breath or diaphoresis (sweating). He has a history of hypertension and elevated "bad cholesterol" on appropriate medication. His vital signs are normal except for a heart rate of 106/min and he appears anxious. Exam is otherwise normal. His EKG is normal and cardiac enzymes are not elevated. He is admitted to the hospital.

Inpatient or observation?

Risk area: Chest pain

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After complex review the RAC denies the admission because "the services could have been provided in a less intensive setting." The hospital reviews the chart to prepare an appeal.

Scenario 1: EDP clinical impression: "Chest pain"

Admitting H&P: "R/O MI"

Scenario 2: EDP clinical impression: "ACS"

Admitting H&P: "This is a 71 year old man with risk factors for CAD who presents with new onset of angina-like chest pain consistent with unstable angina. This puts the pt at risk for AMI, heart failure, cardiac arrhythmia and death. Admit for close monitoring and urgent cardiac evaluation.

Which scenario supports inpatient level of care?

Risk area: Syncope

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A 72 year old woman comes to the ED because she "passed out" at church. Witnesses say she was standing up singing when she suddenly slumped to the floor. She was unconscious for about 2 minutes. When she woke up, she was oriented but didn't remember passing out. She has a history of hypertension and diabetes. She had a heart attack three years ago but hasn't had any recent chest pain. In the ED, the patient was in no distress. Her EKG showed a scar from the previous MI but no acute changes. Cardiac enzymes were not elevated. She was admitted.

Inpatient or observation?

Risk area: Syncope

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- Syncope: Sudden loss of consciousness, loss of postural tone, spontaneous recovery. (Pass out – fall – wake up)
- Low risk syncope: Benign course → Observation
- Moderate to high risk syncope: Risk of injury or sudden death →Inpatient
- Risk assessment by physician →"**Admit as inpatient**"
- Supportive documentation: "Patients with syncope and history of heart disease are at increased risk of life-threatening arrhythmias and death. Requires urgent cardiac evaluation and monitoring of vital signs and cardiac rhythm."

Physician documentation at time of admission:

If you don't write it, you may have been thinking it, but you can't prove it.

Contact information

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