Pearls of Wisdom 2—
Updates & Guidance from the Ever-Changing Work of RAC, MAC, Medicaid and the OIG Audits

Instructor: Day Egusquiza, Pres AR Systems, Inc
The Culture of Audit

A Glimpse from the National Landscape
National Error Rate
Summer 2010 – 12.4%; 2011–10.5%, 2012–7.0%

- Commitment to Reduce the Error
  President Obama recently announced the government’s commitment to reduce the error rate by 50% (using a baseline of 12.4%) by 2012 (2008 3.6% $10.3 Billion)
  - 9.5% for November 2010 Report
  - 8.5% for November 2011 Report
  - 6.2% for November 2012 Report
  Thru MAC, CERT, ZPIC, RAC, MIC, OIG, HEAT auditing…
  Funding PPACA by eliminating fraud, waste and abuse…
NEW: “Medicare Audit Improvement Act of 2012”

- Rep Graves (R-MO) and Schiff (D-CA) introduced HB 6575.
- AHA strongly supports the much needed improvements to the RAC and other audit programs.
- Key elements within the legislation:
  - Establish a consolidated limit for medical record requests – from all audit groups
  - Provide penalties for poor performance/errors
  - Restore due process rights under the AB rebilling demonstration project.
  - STAY TUNED 10–12
## 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

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

Require CMS/HHS to allow for complete rebilling of all outpatient covered services – similar to the RAC Demo project.

Require CMS/HHS to allow for appeals, due process, within the Part B Rebilling Demo project.

AHA meets regularly with CMS and requests providers continue to submit examples of abuse, etc. as this is the best way to ‘show’ problems, rather than stories.
NEW: Section 628 of the Fiscal Cliff Bill (HR8) amends Section 1870 of the Social Security Act

- Major hit:
  - ‘For purposes of clause (b) of paragraph (1), such provider of services or other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary’s determination that more than such correct amt was paid was made subsequent to the third year (now fifth year) following the year in which notice was sent to such individual that such amt has been paid; except that the Secretary may reduce such three-year (now five-year) period to not less than one year if he finds such reduction is consistent with the objectives of this title.” (SS Act, Section 1870 b, 4)
Additionally –is there the potential for a 5 year look back? YES

- Although the Fiscal Cliff legislation ‘appears to expand to 5 years, there is already legislation that allows for a 5 yr look back.
- Statement of work only indicates 3 years at this time.
- Tax Relief and Health Care Act of 2006 allowed for up to a 5 year look back period – current fiscal year and 4 prior fiscal years.
April 2012– Trustee report

- Social Security, monthly income, fund depleted in 2033. 3 years earlier than 2011
- Supplementary Medical Ins/Part B, is funded by premiums and general revenue.

Weblink: https://mail.google.com/mail/u/1/?shva=1#box/T3bpab26aca5247d7 (Thanks, RAC Summit)

- Fixes?
  - Rep Ryan supports – each recipient a set amt each year to buy medical insurance.
  - Reform focus will save Medicare $200B thru 2016, added 8 years. (USA Today 4–24–12)
  - Waste reduction/Health Affairs blog/Institute Of Medicine $765B a year wasted in unnecessary tests, inefficient delivery systems, adm costs, pricing.
- Audits

RAC 2013
Recent CMS Inpt activity

- Atlantic Health System/NJ to pay $9M for alleged Medicare overbilling to resolve whistleblower allegations that they overbilled Medicare for about seven years (2002–09) by admitting pts on an inpt basis rather than the less–costly outpt basis to boost reimbursements, the US Justice Dept announced 6–21–12. They also entered a 5 year Corporate Integrity Agreement.

- Six Christus Spohn Hospitals/TX in Corpus Christi–Shoreline, Memorial, South, Alice, Beeville and Kleberg collected more money than they should have by billing inpt codes when outpt codes were appropriate, the US Attorney stated. The investigation into the charges began in March. The whistleblower will receive 20% or about $1m of the $5m settlement. (6–26–12)
First report to Congress – FY 2010

- “Implementation of Recovery Auditing at the CMS. FY 2010 Report to Congress as required by 6411 of Affordability Act.

- Accuracy rate by the RACs: Low to high: DCS/98.6 – HDI/ 99.2%

- $75 M in overpayments. 82% of all activity

- 16 M in underpayments. 18% of all activity

- Reasons:
  - Not coded correctly
  - Not meeting Medicare’s guideline for an inpt
  - Supporting documentation does not match the order.
Goal of the Audit Culture

- To ensure billed services are reflected in the documentation in the record
- To ensure billed services are in the medically correct setting for the pt’s condition
- To ensure billed service reflect the ‘rules’ regarding billing for the specific service
- To ensure documentation can support all billed services according to the payer rules.
  NOT IF THE CARE WAS APPROPRIATE
The MACs/Medicare Claims Contractor increased the risk thru pre-payment auditing. The first MACs to begin pre-payment:

- First Coast/Florida Trailblazer/Ok, TX (Novitus)
- Highmark/Novitus/PA = began auditing for the appropriateness of the documentation to support the procedure/service. Palmetto = Physician E&M (9–12)

The facility is not paid until the documentation is reviewed to determine if the record can support the procedure...not the setting! HUGE change...
Govt Audits – in a nutshell

**RAC**
- Post payment – up to 3 yrs last payment activity, New Issue Bd
- Pre-payment Demo project, slated for 3 yrs, 11 states

**MAC**
- Pre-payment – identified items/inpt and outpt, physician, MAC specific

**Medicaid**
- Post payment – probes, CERT, other, MAC specific
- Internal, state-specific fraud unit
- MIC – up to 5 years back
- RAC for Medicaid – incentivized for recoupment/% of $–3 yrs back
- +OIG+QIC+ZPIC

RAC 2013
Updates Impacting the RAC PROGRAM
Updated Statement of Work 9–11

**Highlights**
- Allows /outlines Semi Automated Reviews
- RAC decisions beyond 60 days = no payment to the RAC but can request an extension.
- Discussion period continues but no timelines for replies from the RAC. Should be in writing and responded to within 30 days of receipt. If appeal is filed, discussion period ends.
- Posting of new issues still a problem with HDI and Connolly. But no new guidelines for the RACs
- Timely period between results letter and demand letter. (Estimated at 2 weeks)
  (CMS’s website, posted 9–1–11)
Semi-automated reviews are a two-part review that is now being used in the Recovery Audit Program. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has a high index of suspicion to be an improper payment. The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that was identified.

Still no limit on requests; in addition to complex record requests.
All RACs have begun doing (4–11)
Using the automated review/data mining to identify billing abnormalities with a high potential for improper payment.
This is followed by a request for records/complex to audit to determine if an error did occur in charge capture or claim’s submission.
EX) Tx hospital: Cataract removal can occur once per eye for the same date of service. 66984/removal with insertion of lens AND 67010–59 removal with mechanical vitrectomy) created the edit. 59 overrode edits = 2 payments.
Jan 2012 RAC updates – Building on 2011 – 3 goals

**Demonstration Pre-Payment Review – focused**
- 7 states with high fraud and error prone providers: FL, CA, TX, MI, NY, LA, IL
- 4 states with high volume of short stay hospital stays: PA, OH, NC, MO
- Does not replace Pre for MACs
- Should allow for more timely rebills of corrected claims while catching potential patterns early.

REACTIVATED: Aug 27, 2012–2015/3 years

**Prior authorization of certain medical equipment.**
(www/cms/gov/apps/media/Press/factsheet.asp?counter 2013 19

**Part A to Part B Rebilling**
- 380 hospitals /pilot can sign up to volunteer
- All hospitals to resubmit claims for 90% of the allowable Part B payment when RAC, CERT, MAC finds that a Medicare pt met Part B, not Part A.
- NO APPEAL RIGHTS if join this demonstration project.
- Can opt out at any time.
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.

MAC ADR letter will advise where to send: RAC or MAC.

30 days to reply; will receive determination w/in 45 days.

Beginning in Aug 2012–

312/Syncope

Jan (Connlley) 069/Transient Ischemia(TIA); 377/GI hemorrhage w/MCC

1st Q 2013– 378/GI Hemorrhage w CC; 379/GI Hemorrhage w/o CC/MCC

TBD– 637/diabetes w/MCC; 638/diabetes w/CC; 639/diabetes w/o CC/MCC

RAC @cms.hhs.gov

Effective March 15, 2012, calculation for record count has increased.

“The limit is equal to 2% (use to be 1%) of all claims submitted for the previous calendar year divided by 8. EX) billed 156,253 claims, 2% = 3125 /8 = 390 every 45 days”

“RAC can request up to 35 records per 45 days for providers whose calculated limit is 34 or less”

“Maximum # of records per 45 is 400” (was 300)

“Providers with over $100,000,000 in MS-DRG payments who had the 500 requests cap will now have a 600 record cap”

Hospital feedback on 3–16: GA “went up 118%; Al doubled, Texas up by 100 records each 45 days, NC up by 87 records, IN 300–400 between our 3 hospitals.”

EXCEPT CGI – providers report a reduction in their records (10–12)
2–11 CMS announced a revised threshold for hospitals with $100 million in Medicare payments. The cap was raised to 500 per 45 day period, up from the 300 cap. AHA expressed concern over the 87 hospitals that will be impacted by this change. (New #, 3–12, 600)

PIO hospitals will begin to have records requested 2nd Q 2012. Demand letters as of 1–13; recoupments up to 30% of PIP dollars to a maximum of 1000 claims per jurisdiction. (NGS and Cahaba posting)

Watch for spike in Region A $ as many PIP hospitals are in this region.
Physician/Non PP Additional Documentation Limits

- As of 2–14–11, modified changes
- Limits based on physician or non PP’s billing Tax ID # as well as the first three positions of the ZIP code where that physician/non PP is physically located.
- EX: Group ABC has TIN 12345 and two physical locations in ZIP code 4567 and 4568. This group qualifies as a single entry for additional documentation requests/ADR.
- Ex: Group XYZ has TIN 12345 and two physical locations in ZIP 4556 and 5566. This group would qualify as two unique entities for ADR.
More on Physician ADR

ADR limits will be based on the # of individual rendering physician/non–PP reported under each TIN/ZIP combination in the previous calendar year. Reserves the right to exceed the cap if indicated.

<table>
<thead>
<tr>
<th>Group/Office Size</th>
<th>Maximum # of requests per /each 45 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 or more</td>
<td>50 records</td>
</tr>
<tr>
<td>25–49</td>
<td>40 records</td>
</tr>
<tr>
<td>6–24</td>
<td>25 records</td>
</tr>
<tr>
<td>Less than 5</td>
<td>10 records</td>
</tr>
</tbody>
</table>
Physician Focus Areas

- Place of Service – outpt hospital vs office (SE1104 Med Learn; 11 vs 22 or 23)
- Separate E&M leveling within the surgical/CPT bundle period
- New vs Established
- Level of service conflicts with the hospital – doc /inpt; hospital/OBS
- Based on CERT audit results/ West coast, the following was targeted for audit: (2011)
  - 99214 Region C–99215 (10–12)
  - 99223 (Initial day)
  - 99233 (Subsequent hospital visit)
- Cert audits can trigger requests for records if provider history shows an abnormal volume/risk for targeted CPT codes
- Office E&M leveling/bell curve is not a focus of the RAC audits..yet
Connelly audits:

Example #1: Physician E&M visit with a CPT coded procedure.

- EX) 99283 & 12011/laceration repair
  - DX: 719.43 wrist pain, 719.46 knee pain,
  - 873.40 open wound of face.

RAC requested monies back because E&M on the same day as procedure.

Pt was not just seen for the laceration repair, they fell and had other issues.
Another E&M physician audit

- **Example #2**
- Patient presented to office for incision and drainage of abscess on the leg.
- The pt’s appt was for this service. (Key)
  
  10061 682.6 abscess of leg
  
  • 99212–25 682.6 abscess of the leg
  • 25 modifier = separate, identifiable E&M with the CPT

RAC asked for funds back as the pt came in for the service, and the E&M visit was not separately identifiable thru the documentation.

(Thanks to Margie McLean, QMACS, Inc/RAC Summit)
More Pt Protection and Affordable Act (PPACA)

“Most of the healthcare reform can be paid for by finding savings within the existing health care system, a system that is currently full of waste and abuse.” Pres. Obama

- Requires report and repayment of overpayments.
- “Overpayment’ = funds a person receives or retains to which person is not entitled after reconciliation.
- Providers and suppliers must: Report and return overpayments to HHS, the state or contractor by the later of:
  - 60 days after the date the overpayment was identified or
  - The date the corresponding cost report is due.
- Provide a written explanation of the reason for overpayment (PPACA 6402)
- Retaining overpayments after the deadline for reporting is subject to False Claims Act and Civil Monetary Penalties law.
2013 OPPS proposed rule – New direction on defining an Inpt

- Defining inpt at a specific period of time
- Along with providing a limit on how long a beneficiary receives obs services.

Industry chatter:
- If a 24 hr bright line rule for inpt status is enacted, the overall impact will be beneficial for providers.
- UR would be highly focused on the ‘immediate placement’ in a bed –rather than after 24 hrs.
- Focus of recovery auditors will be on inpt stays less than 24 hrs.
“Living with RAC”
(OR the world according to RAC)
2307 hospitals have participated in RAC TRAC since data collection began in January of 2010. 1299 hospitals participated this quarter.

Participants continue to report dramatic increases in RAC activity: Medical record requests are up 21% relative to last quarter.

The number of denials is up 23% relative to last quarter.

The dollar value of denials is up 26% relative to last quarter.

Nearly two-thirds of medical records reviewed by RACs did not contain an overpayment, according to the RAC.

94% of hospitals indicated medical necessity denials were the most costly complex denials.

61% of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting.
American Hospital Assoc (AHA)
RACTrac (aharactrac.com)
3rd Q 2012 Executive Summary

- The majority of complex denials are short-stay medical necessity denials. Ave $5556
- 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.
- 89% of all respondents have had RAC activity 3rd Q 2012,
- Region C/Connelly had the largest # of hospital reporting activity.
- $6.1B were targeted for potential recoupment thru the medical record requests.
- Denials reflect $1.1B in complex denials thru 3rd Q, up 26% from 2nd Q 2012.
- 3rd Q: $662,710 req/$200,941 denied = 30%
AHA/RAC Denials by Reason: 3rd Q 2012
96% of denied $ were complex

<table>
<thead>
<tr>
<th>Region</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Unnecessary Admission/incorrect setting</td>
<td>71%</td>
<td>70%</td>
<td>85%</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>Incorrect DRG or other coding error</td>
<td>24%</td>
<td>26%</td>
<td>11%</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>No or insufficient documentation</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Incorrect APC or OP billing code</td>
<td>2%</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Complex Denials/Setting By Dollar

<table>
<thead>
<tr>
<th>% of Complex Denials for Lack of Medical Necessity for Admission – thru 3rd Q 2012/4th Q 2011- by $$ Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope and collapse (MS-DRG 312)</td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)</td>
</tr>
<tr>
<td>T.I.A. (MS-DRG 69)</td>
</tr>
<tr>
<td>Chest pain (MS-DRG 313)</td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure (PCI) w non-drug-eluting stent w/o MCC (MS-DRG 249)</td>
</tr>
<tr>
<td>Esophagitis, gastroent &amp; misc digest disorders w/o MSS (392)</td>
</tr>
<tr>
<td>Back &amp; Neck Proc exc spinal fusion w/o CC/MCC</td>
</tr>
</tbody>
</table>
Underpayments Paid to Hospitals: thru Q4 2011 thru 3rd Q 2012 = $92 M pd to providers

<table>
<thead>
<tr>
<th>% of Hospitals with Underpayments by Reason for Underpayment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect MS–DRG</td>
<td>61%/64/63%</td>
</tr>
<tr>
<td>Inpatient Discharge Disposition</td>
<td>21%/30/29%</td>
</tr>
<tr>
<td>Billing Error</td>
<td>9%/5/7%</td>
</tr>
<tr>
<td>Outpatient Coding Error</td>
<td>8%/7/5%</td>
</tr>
<tr>
<td>Other</td>
<td>15%/13/11%</td>
</tr>
</tbody>
</table>
RAC Appeals: 3rd Q 2012/1st Q 2012

(More than 1/3 overturned during discussion period. Value of appealed claims: approx $600,000)

<table>
<thead>
<tr>
<th>Region</th>
<th>% of denials appealed</th>
<th>Appeals pending (3/4 still unresolved, 3rd Q as well as 2 previous Q)</th>
<th>% of denials overturned on appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>51/41</td>
<td>6,177*PIP</td>
<td>82/70%</td>
</tr>
<tr>
<td>Region B</td>
<td>39/40</td>
<td>12,729</td>
<td>82/84%</td>
</tr>
<tr>
<td>Region C</td>
<td>37/27</td>
<td>25,873</td>
<td>77/79%</td>
</tr>
<tr>
<td>Region D</td>
<td>48/43</td>
<td>23,636</td>
<td>61/55%</td>
</tr>
<tr>
<td>National</td>
<td>42/34%</td>
<td>68,415</td>
<td>74/75%</td>
</tr>
</tbody>
</table>
## Medicare Fee-For-Service RAC program Appeals Update–June 2012

<table>
<thead>
<tr>
<th># of claims w/overpayment determination</th>
<th>903,372</th>
</tr>
</thead>
<tbody>
<tr>
<td># of claims where the provider appealed</td>
<td>56,620</td>
</tr>
<tr>
<td># of claims w/appeal decisions in provider’s favor</td>
<td>24,568</td>
</tr>
<tr>
<td>% appealed claims w/favorable decision</td>
<td>43.4%</td>
</tr>
<tr>
<td># of claims where provider did NOT appeal</td>
<td>846,752</td>
</tr>
<tr>
<td>% of claims overturned on appeal for ALL denials</td>
<td>2.7%</td>
</tr>
</tbody>
</table>
## CMS Quarterly Newsletter –

*Jan – March 31, 2012 (1st Q totals)*

<table>
<thead>
<tr>
<th>Region</th>
<th>Overpaymts ($ in millions)</th>
<th>Underpaymt</th>
<th>Total Corrections (Based on actual collections)</th>
<th>FY to Date Corrections Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A/DCS</td>
<td>$112.6</td>
<td>$11.3</td>
<td>$123.9</td>
<td>$146.3</td>
</tr>
<tr>
<td>Region B/CGI</td>
<td>$60.8</td>
<td>$4.8</td>
<td>$65.6</td>
<td>$137.7</td>
</tr>
<tr>
<td>Region C/Connolly</td>
<td>$202.8</td>
<td>$20.1</td>
<td>$222.9</td>
<td>$343.0</td>
</tr>
<tr>
<td>Region D/HDI</td>
<td>$212.2</td>
<td>$25.3</td>
<td>$237.5</td>
<td>$390.2</td>
</tr>
<tr>
<td>Nationwide Totals</td>
<td>$588.4</td>
<td>$61.5</td>
<td>$649.9</td>
<td>$1,072.6</td>
</tr>
</tbody>
</table>
Top Issues per Region: Jan–March 2012

Three of the four RACs had the same issue that reflected the majority of the denials:
- Cardiovascular procedures (medically incorrect setting)
- HDI – continues to post minor surgeries and other treatment billed as an outpt. (1 issue continues to exceed all others from the 3 RACs)

**CMS RAC program update** Oct 2009–May 2012
- Overpayments $1.86B
- Underpayments $245M
- Total corrections: $2.1B
### Medicare Fee for Service RAC Program, FY 2010 – FY 3rd Q 2012

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Overpaymts Collected</td>
<td>$75.4M</td>
<td>$797M</td>
<td>$397.8M</td>
<td>$588.4M</td>
<td>$657.2M</td>
<td>$2.5B</td>
</tr>
<tr>
<td>Underpaymt Returned</td>
<td>$16.9M</td>
<td>$141.9M</td>
<td>$24.9M</td>
<td>$61.5M</td>
<td>$44.1M</td>
<td>$289.3M</td>
</tr>
<tr>
<td>Total Corrections</td>
<td>$92.3M</td>
<td>$939.3M</td>
<td>$422.7M</td>
<td>$649.9M</td>
<td>$701.3M</td>
<td>$2.8B</td>
</tr>
<tr>
<td>Overpayment issues</td>
<td>Region A/Proformant/DCS</td>
<td>Region B/CGI</td>
<td>Region C/Connelly</td>
<td>Region D/HDI</td>
<td>PENDING APPEALS? May significantly change figures.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovas Procedures/Inpt</td>
<td>Cardiovas Procedures/Inpt</td>
<td>Cardiovas Procedures/Inpt</td>
<td>Minor surgery and other treatment billed as inpt</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If the inpt is denied, –then what

- Initial claim submission of Part B on a Part A claim is allowed. No Obs, no surgery, no anesthesia, no recovery. Ancillary only.
- Rebilling of a denied inpt claim within the timely rebilling requirements is a Part B on a Part A claim. Bill type 12x. Ancillary only.
- HOPE: AHA continues to champion trying to get CMS to allow bill type 131/regular outpt for a rebilled denied claim.
- **Transmittal R2386CP/3–12** – Bill 131 for services up to the point of the erroneous inpt order. Bill 121 for all services after the order.
New Twist with the ALJ hearing

- Major backlog – anticipate 2 years
- Providers are being encouraged to ‘ask for Part B ‘benefits – that would doing the rebilling as bill type 131 (outpt surgeries included). This would be in addition to having the PART A appeal heard.
- ALJs are “remanding” the case back to the level 2/QICs if there is nothing in the case regarding the pt’s Part B benefits…even if the provider didn’t ask for Part B considerations. (1/31)
Orders take effect when written. Pt’s condition must meet inpt at the time of the order.

- Initial observation order was determined at later point in time to have been inappropriate as patient should have been admitted as an inpatient. Order is written for inpatient care on different date than referral to observation. Since orders cannot be retroactive, the admission date is the date the inpatient order is written, even if patient could have been inpatient when the observation order was written.
- Note: When an admission order is written but the patient status no longer supports the need for inpatient admission, the claim cannot be billed as an inpatient claim.
- **Example 1:** Patient arrives to ED on 03/28/11. Order is written for observation stay. On 03/29/11, determination is made that patient could have been an inpatient starting on 03/28/11; however, patient no longer requires inpatient services. At this point, an order for inpatient admission could not be valid. The claim cannot be billed as an inpatient claim.
- From: [https://www.noridianmedicare.com/provider/updates/docs/InpatientOrders.pdf?3f](https://www.noridianmedicare.com/provider/updates/docs/InpatientOrders.pdf?3f)
Outpt Complex Reviews

- **Basic Radiation Dosimetry Calculation** – Outpt- CPT 77300
  Comparison will be made in regards to units of Dosimetry calculations reported in the medical record versus those units of dosimetry calculation reported on the claim, to establish whether a difference in reported units compared to those documented resulted in an overpayment for CPT 77300.

  HDI has issued “minor surgery and other treatment billed as an inpt stay” Claims billed for minor surgery or other treatment are identified for medical review based on risk of inpt improper payment.” (Oct 2010)

  MAC/NGS has begun PREPAYMENT probes for outpt.

  Nov 2012 = 99211 for hospital /technical component of HBC visit.
False Claims and Kickback Lawsuits Involving Hospitals and Health Systems” – Becker’s Hospital Review, 7–11

“Louisville, KY based Norton Healthcare agreed to pay the federal govt $782,842 in March to settle allegations that it overbilled Medicare for wound care, infusion and cancer radiation services by adding a separate E&M charge that should have been included in the basic rate. The alleged overbilling, which occurred between Jan 2005–Feb 2010 involved outpt care. The settlement is twice the amt Norton allegedly overbilled.”

ISSUE: Transmittal A–00–40, A–01–80 indicate that there is inherent nursing in all CPT codes. Therefore, the facility must ‘earn an E&M when done with a procedure.’ Unlikely events, other medical conditions being treated, new pt=examples.
Connolly – Drug dosages /multiplier issues

- June, 2010  Connolly posted new issues relative to drug /J code accuracy. Tying the J code and the units/multiplier on the UB.
- Paclitaxel
- Cetuximab
- Paclitaxel protein –bound particles
- Tenectplase
- Pamidronate disodium
- Adenosine
- Zoledronic acid (reclast) 1 mg
How does that interest work?

- Charged to the provider if demand amt is not paid within 30 days of the letter. 31–41st days of interest, auto recouped on 41st day.
- Charged to the provider if an appeal is filed within 30 days (normal is 120) to stop the recoupment.
- Paid to the provider if the money was recouped on the 41st day, appeal filed and overturned.
- No interest is paid if the money is given back voluntarily, even if over turned on appeal.
- Interest is each 30 days, not compounded. 11%
- Reference: CR7688 /July 12, updates CR683/Sept 08
Additional Documentation Request “Sample”

- HDI and CGI have started sending their ‘New Issue Validation’ sample letters.
- Statement of Work allows sampling of up to 10 claims (in addition the 45 day limit) to prove a vulnerability with a new issue. Results will be issued on the findings with data submitted to the New Issue Board/CMS.
- HOT: Share what was requested so potential new items are known; preventive work.
- EX) Readmission within 30 days for AMS.
MAC ATTACK: Medicare Contractor Updates
And Medicaid, OIG.....
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 41st day with interest.
- No published items; no limits on requests, same appeal rights. Letters SOMETIMES explain..

- **NHIC** – Prepayment auditing of Chest pain, syncope and collapse, CHF.
More MAC pre-auditing

- NGS – recent updated posting of pre-payment
  - 1 day stays
  - Ventilator services during an inpt admission (correct hrs = different levels of DRG) E&M services with a CPT code (25 modifier)
  - Rehab services – KX modifier
  - Dx services – Exam, spine, thoracic to determine medically necessity and correct coded services
  - Drugs – injection/Oxaliplatin 0.5 mg to determine medically necessity and correct coded services
  - 10–12 NEW Documentation “cloning’ guidance
  
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 widespread auditing. Using CERT data for more probes
- **WPS** released a CERT review of Epidural Steroid Injections w/large error rate. (1/31) (LCD30481)
  Prepayment 310, 313, 192, 690
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 3rd 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)
MACs are beefing up prepayment auditing – with physician impact

- **Trailblazer/Novitas**: 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
We have had prepayment denials from Novitas (Highmark) in addition to our RAC denials. For the Prepayment Denials, we send appeal with additional information from the doctor’s office notes. They are looking for 4 key elements:

- Level of Pain and Effect on ADLs
- Response to Treatment with Medications: NSAIDS and Injections
- Response to Treatment with other modalities: Assist Devices, Braces and PT
- X Ray Findings

In the past, it was ok to just say “did not respond to conservative treatment”. Now they want details documented.

**NOTE:** Med Learn SE1236  Documenting to support medically necessity of DRG 470

**American Association of Hip & Knee Surgeons/AAHKS,** June 2012 publication. Created a check list to assist surgeons with the required documentation elements.

**Suggestions:** Surgery scheduling joins the UR prevention team. Education on new checklist requirement in the medical record /surgical H&P. Validate it is present prior to procedure. UR works with the Surgeon; surgery works with the surgeon. Alternative idea: Include the physician’s notes with the Hospitals. Alert: Many HIM depts would not submit these as they may not be identified as part of the legal medical record. Also some state limitations. Explore HIPAA privacy issues for non-hospital records for treatment, payment or operations.
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

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>2009 Error Rate</th>
<th>2010 Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>313</td>
<td>Chest pain</td>
<td>55.16%</td>
<td>76.71%</td>
</tr>
<tr>
<td>552</td>
<td>Medical back pain w/o MCC</td>
<td>70.92%</td>
<td>71.25%</td>
</tr>
<tr>
<td>392</td>
<td>Gastro &amp; misc disorders w/o MCC</td>
<td>49.08%</td>
<td>41.93%</td>
</tr>
<tr>
<td>641</td>
<td>Nutrition misc metabolic disorder w/o MCC</td>
<td>49.27%</td>
<td>48.43%</td>
</tr>
<tr>
<td>227</td>
<td>Cardiac defib w/o cath lab w/o MCC</td>
<td>20.65%</td>
<td>45.43%</td>
</tr>
</tbody>
</table>
“Improper payments and inpt prepayment review medical review – update (3–12)”
Outlines the prepayment rollout and % per DRG. (Sample above)

<table>
<thead>
<tr>
<th>Prepayment Impl date</th>
<th>Review %</th>
<th>Affected MS–DRGS</th>
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</thead>
<tbody>
<tr>
<td>3–12–12</td>
<td>30%</td>
<td>153/otitis, 328/stomach, 357, 455, 473, 517</td>
</tr>
<tr>
<td>2–12–12</td>
<td>30%</td>
<td>242/pacemaker, 247/percut cardio, 264/other cir OR procedure, 287/cir disorder</td>
</tr>
<tr>
<td>1–1–12</td>
<td>Increased 50%</td>
<td>470 (major joint, lower extremity)</td>
</tr>
</tbody>
</table>
More MAC auditing

- **Palmetto**, Pre Payment Auditing
- **Began early 2012** (Site: CA site. Prior to Feb, 2012 – never had a pre-payment audit request. Had 12 in 1st request.)
- **DRGs focus:**
  - 871 Septicemia/Sepsis
  - 641 Misc disorders of nutrition
  - 690 Kidney / UTI
  - 470 Joint replacement
  - Probe 227/inpt implant with defib w/o cath or CC or MCC. Aver $ 42,298. Rebill – ancillary only (11-12)

**J15/CGS:** DRG 308–310, post payment Cardiac Arrythmia audit (KY and Ohio).
123 claims. 55 denied. Due to ‘moderate error rate of 36.4%, continued complex auditing will occur.
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)
WOW! Palmetto has been conducting pre-payment audits since Sept 2012 in NV, Hawaii, CA – focusing on high levels – 99214–99215 (1–13)

www.palmettobga.com/palmetto/providers.nsf.docs?CAT/Jurisdiction

<table>
<thead>
<tr>
<th>PRE pay</th>
<th>Location</th>
<th>Denials</th>
<th>Missng-Incom</th>
<th>Level not support</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Palm/</td>
<td>Hawaii</td>
<td>1,702</td>
<td>41%</td>
<td>41%</td>
<td>9%</td>
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<tr>
<td>GBA</td>
<td>Nevada</td>
<td>1,834</td>
<td>46%</td>
<td>42%</td>
<td>6%</td>
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<tr>
<td>No CA</td>
<td></td>
<td>1,313</td>
<td>63%</td>
<td>18%</td>
<td>12%</td>
</tr>
<tr>
<td>So CA</td>
<td></td>
<td>1,634</td>
<td>61%</td>
<td>18%</td>
<td>12%</td>
</tr>
</tbody>
</table>
OIG’s 2011–12 Work Plan – Risk Areas for Hospitals

- Outpt claims pd greater than charges. (APC methodology)
- Inpt claims pd greater than chgs
- Inpt $ greater $150,000
- Outpt $ greater $25,000
- One day stays at acute care
- Major complications /comorb
- Payments for septicemia servs
- Payments for inpt same day discharges and readmissions
- Outpt claims billed during the DRG payment window

- Payments for hemophilia
- Payments for outpt surgeries w/units greater than 1
- Inpt and outpt claims /manufacturer credits for replacement of devices
- Post –acute transfers to SNF/HHA/another acute care inpt facility
- SNF/HHA consolidated billing–separate outpt services
- Outpt claims with 59 modifier
- Inpt claims pd greater than chgs
- FLAGGED? PEPPER & patterns
Quick Updates – Medicaid

- 9-14-11 CMS issued new RAC for Medicaid final rules
  Patterned after Medicare RAC – 3yr look back, prohibits auditing done by another group, set limits on medical record requests, notify of overpayment in 60 days and coordinate.
  - www.medicaid-rac.com

- 2-16-11 CMS proposes Medicaid payment reductions for provider-preventable conditions
  Follow Medicare’s hospital acquired conditions
Medicaid is auditing

- 1) Medicaid integrity contractors – CMS has established a 5 year look back period with 30 days to reply to requests for record (10–1–10)
- 2) RAC for Medicaid – Final rule out Sept 14, 2011. To have in place by Jan 1, 2012. Target: $2.1B, with $900M to the states
- 3) State Medicaid – state fraud units are auditing and coordinating all data for audits.
- Concern – avoid duplication! 3 unique groups. Track and watch each one separately.
- NOTE: Medicare RACs are also becoming Medicaid RACs. (HDI–Ks)
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\textsuperscript{nd} test due to protocol. (Noridian/Nov 2009)
- EX) Without contrast but 2\textsuperscript{nd} one done with contrast based on protocols.
- Ensure the order is either updated or the initial order clearly states ‘with protocol as necessary.’
- \textit{YEAH – how about including the protocols that are referenced in the record when submitting for audit?}
Creating a New Culture

A roadmap to increased ownership, reduced risk and keeping your payments
SE1024 “RAC: High Risk Vulnerabilities– No documentation or insufficient documentation submitted” (July 2010)

Two areas of high risk were identified from the demonstration project:

- No reply to request/timely submission (1 additional attempt must be made prior to denial)
- Incomplete or insufficient documentation to support billable services
Additional CMS/MedLearn Training

- SE1024/July No documentation or insufficient documentation submitted
- SE1027/Sept Medical necessity vulnerabilities for inpt hospitals
- SE1028/Sept DRG coding vulnerabilities for inpt hospitals
- SE1036/Dec Physician RAC vulnerabilities
- SE1037 /Jan 11 Guidance on Hospital Inpt Admission (referencing CMS guidelines, does not mandate Interqual/Milliman, RAC judgment allowed)
- SE1104/Mar 11 Correct Coding POS/Physicians
- Special Edition #SE1121/June 11 RAC DRG Vulnerabilities –coding w/o D/C summary
- SE1210/Mar 12 RAC with MN of Renal & Urinary Tract Disorders
- SE1236/Sept 12 Documenting Medical Necessity of Major Joint Replacement (hip and knee) DRG 470
“All entries in the medical record must be complete. Defined by: sufficient info to identify the pt; support the dx/condition; justify the care, treatment, and services; document the course and results of care, treatment and services and promote continuity of care among providers.

“All entries must be dated, timed and authenticated, in written or electronic format, by the person responsible for providing or evaluating the service provided.”

“All entries must be legible. Orders, progress notes, nursing notes, or other entries ..... (Also CMS covers in SE1024 MedLearn release)
Outline of Internal Challenges

- **Common issues:**
  - Dept leadership not understanding the ownership of accuracy of orders to charges to billed.
  - **Fix:** Daily charge reconciliation—scheduled against completed.
    - MEU: 2 initial first hrs of hydration. Could happen, but rare. **FIX:** ER to OBS. ER is completing their drug adm charge ticket and OBS does theirs. They do not ‘see’ the others so duplication or errors in hierarchy occur. Identify a charge capture analyst for all drug adm. At the conclusion of OBS, 1 ticket, 1 touch, 1 correct charge. Documentation variances identified.
More common internal challenges

- **DRG validation**
  - Budget cuts resulted in less coder validation audits. Education thru audit was lost or greatly reduced.
  - Physician querying for clarity delays submission of claims and cash flow
  - MedLearn/RAC findings indicated that DRG changes (up and downward) were the result of records final coded without discharge summaries. Challenging as to wait for the d/c summary = significant cash delays. Common practice – code with queries for clarity. (Special Edition #SE1121/June 11 RAC DRG Vulnerabilities –coding w/o D/C summary)
  - Safety net – audits to review DRG changes from D/C summary. Track by provider with a hx of ‘surprises’.
Concurrent auditing of 2nd opinions for pt status

- Ensure the attending/provider directing care receiving the 2nd 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.
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.
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.
- This will also help prepare facilities for ICD 10...
- Tie in the coder’s queries to track and trend documentation challenges, per provider.
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.
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.
Working together to reduce risk and improve the pt’s story

- **Joint audits.** Physicians and providers audit the inpt, OBS and 3 day SNF qualifying stay to learn together.
- **Education on Pt Status.** Focus on the ER to address the majority of the after hours ‘problem’ admits.
- **Identify physician champions.** Patterns can be identified with education to help prevent repeat problems.
- **Create CPOE to assist with completeness** of order – Inpt, OBS, with protocol – with reason for decision.
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  866 201 0580
• Region B–CGI   RACB@cgi.com  877 316 7222
• Region C–Connolly  www.connollyhealthcare.com/RAC; RAC info@connollyhealthcare.com  8663602507
• Region D–HDI  racinfo@emailhdi.com  866590 5598
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

JOIN US FOR UR/PA Bootcamp in Chicago
July 22–24