AR Systems, Inc
Training Library Presents

RAC Updates & Implementation

Critical Access Hospitals are Impacted Too

Instructor:

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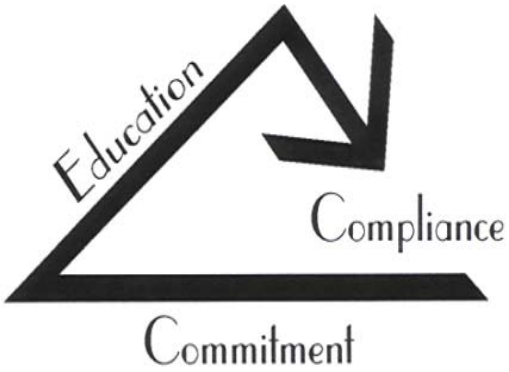


What Leaders Should Know

- Audits are a part of today's culture
- Audits are not just being done by all areas of Medicare . All payers, govt and non-govt, are conducting more aggressive audits.
- "Will we get caught?' sends the wrong message to the staff.
- "What do we need to change if a vulnerability is identified? Looking back vs going forward."

What Leaders Should Do

- Moving forward with process changes, new accountability, ongoing education to reduce vulnerabilities and possible new CASH…..
- While looking back at potential at risk areas of in house documentation by the care team, coding, physician partnerships, and determining appeal status vs repayment while tracking & trending patterns

Outline of Audit At Risks

- **<u>GOAL OF RAC AUDITS</u>: To ensure all billable services (UB, 1500, other billing forms) are accurately reflected in the medical record.**
- **Common issues:**
  - **Dept staff not understanding the charge capture must match physician order and documentation.**
  - **Lack of ongoing coder education**
  - **Lack of ongoing dept head ed**
  - **Lack of physician understanding**
  - **A culture of audit – time to be pro-active**

National Error Rate Summer 2010 - 12.4%

- 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
- – 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…

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 upcoding. To resolve disputes between bene and hospital
CERT	All	Randomly	Small	To measure improper payments
MAC	All	Targeted	Depends on # of claims with improper payments	To prevent future improper payments
RAC	All	Targeted	Depends on the # of claims with improper payments	To detect and correct past improper payments
PSCZPIC	All	Targeted	Depends on the # of potential fraud claims	To identify potential fraud
OIG	All	Targeted	Depends on the # of potential fraud claims	To identify Fraud

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 or 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.

MACs are auditing …

- …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.

The Florida Experience
MAC Focused Probe, 2009 & 2010
Preliminary results , FHA, RAC summit 9-10
Common w/all: No Physician order for inpt

DRG	Description	2009 Error Rate	2010 Error Rate
313	Chest pain	55.16%	76.71%
552	Medical back pain w/o MCC	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%

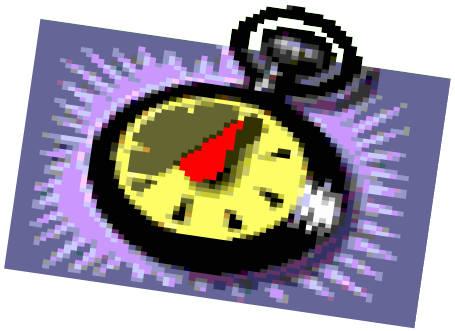
Medicaid is auditing

- CMS has established a 5 year look back period with 30 days to reply to requests for record (10-1-10)
- Medicaid Integrity Program –has audit group
- RAC for Medicaid – state Medicaid units are to identify a RAC auditor by Dec 2010, implemented by April 2011.
- State Medicaid – state fraud units are auditing
- Concern – avoid duplication! 3 unique groups.

Non-Medicare Payers are Auditing

- Commercials – heavy focus on DRG validation
- Tri-Care – DRG validation
- Issues: Do your contracts outline the timelines, scope, and appeal process for post payment reviews?
- Issues: Revising documentation to support billable services is an ALL payer issue

Living with RAC



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 2nd test due to protocol.
- EX) Without contrast but 2nd 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?***

High Risk for CAH –incomplete record

- ER To inpt – two claims are submitted.
- Many times, 2 separate records are maintained.
- When requesting inpt records, the ER records must be included as they contact pivotal events that should support the inpt decision.

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.

Physician Focus Areas – if contacted/hired – 'they are you'

- Place of Service
- Separate E&M leveling within the surgical/CPT bundle period
- New vs Established
- Level of service conflicts with the hospital – doc /inpt; hospital/OBS
- Office E&M leveling is not a focus of the RAC audits …yet

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 know; preventive work.
- EX) Readmission within 30 days for AMS.

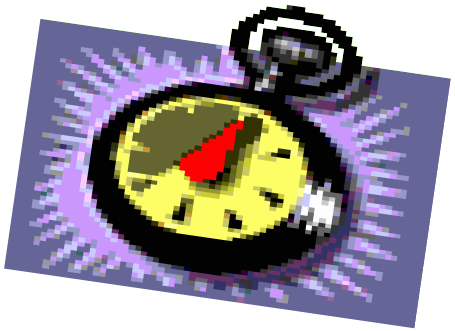
Historical Audit Variances

- AR System's 5 year history of focused audits
- 40% audit variance - 1 day documentation met inpt status.
- 40% audit variance - 1st day of a 3 day SNF qualifying stay
- 60% audit variance – 2nd and 3rd midnight/days met clinical justification to remain in an acute care bed – 3 day SNF transfer

Leadership's Role

- "This is not optional"
- Track and trend to KNOW your historical vulnerabilities –inpt, outpt, OBS, physician partnerships.
- Rapidly, aggressively make changes as identified. EX) EHR/EMR – documentation is too routine, not unique to the interventions done by nursing.

Medical Necessity Has Started…
Connolly, HDI, CGI , DCS +
a little more



The beginning of the Patient's Story

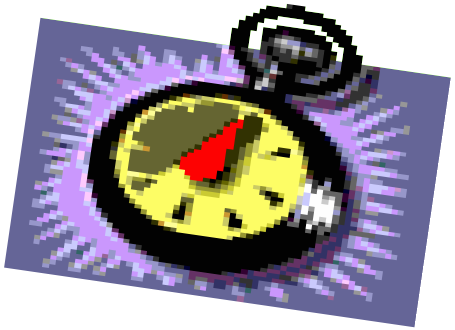
- Connolly , CDI and HDI – Posted June/July 2010
- New issue: Inpt Admissions without a Physician's Inpt Admit Order.
- Description: Admissions to the inpt setting require a physician's order in order to qualify and be paid as an inpt stay.
- Inpt hospital 10-01-07 open
- Reference information to support is posted

Can 1 record be audited for more than 1 new issue?

- Yes but with ground rules
- Always validate ALL issues that are included in the Good Cause letter.
  - Why were your records identified?
  - New issues must be posted
  - Good Cause letter must outline what the issues

Ill hospital example/CGI

- Addition documentation letter received read:
- *"Good Cause for Issue: Chronic Obstructive Pulmonary Disease DRG 88 MS-DRG 190, 191 (Medical Necessity Review and MS-DRG Validation). During the course of the DRG validation, the RAC will also review the record for inpt admission order.*
- *The documentation is being requested because COPD is one of CMS's top volume DRGs. Therefore, DRG 88, currently MS-DRG 190 and 191 was selected to determine if the principle and secondary diagnoses were assigned inappropriately resulting in overpayments to the hospitals. An analysis of your billing data indicates that a potential aberrant billing practice may exist for these MS-DRGs."*



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)

Inpt & Outpt Complex Auditing

- All 4 RACs have posted Inpt DRG validation audits.
- All 4 RACS have posted Medically necessary 'setting' audits. Does the documentation support the level of care that was billed.
- CGI has posted outpt Radiation Oncology
- Connelly has posted J Code multiplier
- HDI has posted minor surgeries done as an inpt.
- TO DO? Begin immediate defense work to determine vulnerability and correct/rebill/disclose.

Inpt Guidance

- CMS does not mandate or endorse any specific guidelines or criteria for utilization review."

Feb 25, 2009 "Evidence-based care guidelines will be used to combat waste in Medicare program."

- ***How to put the puzzle together? Only a physician can direct care; only a physician can order status.***
- ***Use the definition of an inpt 1st, then use Interqual/Milliman as a reference to support the decision.***
- ***However, meeting Interqual does not gurantee an inpt status. Both severity and intensity must be present.***

Medicare's Inpt definition

Medicare benefit policy manual chpt 1 10

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

  "However, 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…"**

All size hospitals are being impacted

- Rural Critical Access hospital. Ave Census 2
- HDI "short stay change notification". "After our review, it is our determination that the claims listed should have been outpt OBS vs inpt." 8-18-10
- Direct admit from a clinic. HDI findings:
- *"Pt chief complaint was hypoxia. The pt presented to ED for acute bronchitis, severe COPD – admitted as an inpt. Past medical hx and the pre-existing conditions are stable. The medical records did not document pre-existing medical conditions or extenuating circumstances that make the acute inpt admission medically necessary. The med record document services that could be provided as an outpt service."*

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.

Last thoughts…

- Begin charge capture/charge reconciliation audits. Department head ownership!
- Begin ongoing reimbursement education with audits of billed services against documentation.
- Focus on identified weaknesses from benchmark audits, RAC automated results and complex reviews – with corrective action plans.
- And the patient will be aware of all recoupments.

Sample letter communication

- *Dear pt*
- *As part of ABC hospital's commitment to compliance, we are continuously auditing to ensure accuracy and adherence to the Medicare regulations.*
- *On (date), Medicare and ABC hospital had a dispute regarding your (type of service). Medicare has determined to take back the payment and therefore, we will be refunding your payment of $ (or indicate if the supplemental insurance will be refunded.)*
- *If you have any questions, please call our Medicare specialist, Susan Jones, at 1 -800-happy hospital. We apologize for any confusion this may have caused.*
- *Thank you for allowing ABC hospital to serve your health care needs.*

CMS Project Officers Contacts

- **Region A (DCS)**
  - **www.dcsrac.com**
  - **info@dcsrac.com**
  - **1-866-201-0580**
  - ***CMS RAC Contact: Ebony.Brandon@CMS.hhs.gov***
- **Region B (CGI)**
  - **http://racb.cgi.com**
  - **racb@cgi.com**
  - **1-877-316-7222**
  - ***CMS RAC Contact: Scott.Wakefield@CMS.hhs.gov***
- **Region C (Connolly)**
  - **www.connollyhealthcare.com/RAC**
  - **RACinfo@connollyhealthcare.com**
  - **1-866-360-2507**
  - ***CMS RAC Contact: Amy.Reese@CMS.hhs.gov***
- **Region D (HDI)**
  - **http://racinfo.healthdatainsights.com**
  - **racinfor@emailhdi.com**
  - **1-866-590-5598 Part A**
  - **1-866-376-2319 Part B**
  - ***CMS RAC Contact: Kathleen.Wallace@CMS.hhs.gov***

- CMS assigns a project officer to each RAC. Use if abuse of the SOW or other issues are occuring.

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Thanks for joining us!

Free info line available.

Provider Options – RAC overpayment determination (Noridian Medicare Part A contractor, 3-10)

Which option should I use?	Discussion Period	Rebuttal	Redetermination
	The discussion period offers the opportunity to provide additional information to the RAC to indicate why recoupment should be initiated. It also offers the RAC opportunity to explain the rationale for the overpayment decision.	A rebuttal should be submitted only on rare occasions of extreme financial hardship. The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment would cause extreme financial hardship. A rebuttal is not intended to review supporting medical documentation. A rebuttal should not duplicate the redetermination process.	A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on the 41st day.

More on Provider Options

	Discussion period	Rebuttal	Redetermination
Who do I Contract	RAC	Contractor/MAC	Contractor/MAC
Timeframe	Day 1-40	Day 1-15	Day 1-120; must be submitted within 120 days of demand letter. To prevent offset on day 41; file within 30 days but interest will accrue (Transmittal 141)
Timeframe begins	Automated review-upon demand letter: Complex-upon results letter	Date of demand letter	Upon receipt of demand letter
Timeframe ends	Day 40 (offset begins on day 41)	Day 15	Day 120