AR Systems, Inc
Training Library Presents

Areas of Risk:

Physician Impact ++

Shared Risk with Partners

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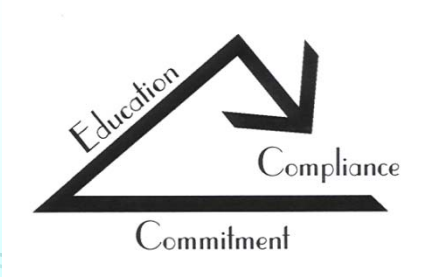

The Environment

- CNN Story line: High error rate on hospital bills.
- Audit your bill as there are many errors that can be found: inflated OR times, duplicate tests, incorrect services billed.

  June 16, 2009

Purpose of RAC

- The RAC program's mission is to reduce Medicare improper payments thru the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent further improper payments.
- The identification of underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medicare program for services which payment is made under part A or B of Title XVIII of the Social Security Act.
- RAC paid for both over and under payments.
- Scope of Work/Statement of Work for the RAC program/CMS/www.fbo.gov/sbg/NHS/HCFA/AGG/reference%2Dnumber%2dcms040001cgs1/listing.htmd or CMS's website

Rollout per CMS, 6-26-09

- CMS has implemented a phase in strategy by review type.
- CMS has not put a phase-in strategy in place by provider type.
- All provider types are available for RAC review once provider outreach has occurred in the state. (Currently being done thru the state hospital associations.)
- And what does that ‘really mean?”

It is all about ‘patterns’

- How will your facility/practice be targeted for a review?
- Remember –the RAC will use proprietary software to determine normal limits, reasonable thresholds, etc. If your history falls outside this norm, it may put you at risk.
- What is at risk: Every line item/outpt UB; every inpt claim; every line 1500 form.

New Issues - CMS and Internal

- New issue board to help ‘approve’ issues to be audited = CMS process
- Once adopted, it will be posted. Each RAC will have their list. No central list at CMS.
- Claims already in review –excluded.
- **IDEA**: *Health systems: Create your own ‘new issue’ list and share with all facilities and employed providers*.
- **IDEA**: *Watch the list carefully and perform defense reviews to assess risk/vulnerability-regardless if it is your RAC.*

Automated vs Complex

- Automated = Does not require a medical record to make a denial/recoupment decision. "Always rules." Units that are unbelievable (Ex: 2 broncs on the same day)
- Complex = Requires a medical record to determine the appropriateness of the care given. (Ex: Correct setting, multiple units with a 59 modifier to override edits.)

Summary: Review & Collection Process

Automated Review

1 New Automated Review Issue Posted to RAC's website

2 RAC makes a claim determination

The Collection Process

3 Carrier/ FI/MAC issues **Remittance Advice (RA)** to provider

N432: "Adjustment based on a Recovery Audit"

4 **Day 1** RAC issues **Demand Letter to Provider** (includes $$$ and appeal rights) INTEREST BEGINS TO ACCRUE AFTER 30 DAYS FROM DETERMINATION

5 **Day 41** Carrier/FI/MAC **recoups by offset**

- Recoupment will NOT occur if:
  - ✓provider has paid in full; or
  - ✓provider filed an appeal BY day 30

From Cmdr Casey, RN, CMS

Complex Review

6 New Complex Review Issue Posted to RAC's Website

7 RAC issues **Medical Record Request Letter** to provider

- Provider has 45 + 10 calendar days to respond
- Providers may request an extension
- Claim is denied if no response

8 Provider submits medical records

9 RAC clinician reviews medical records;

makes a claim determination

- RAC has 60 calendar days from receipt of medical record to send the Review Results Letter

10 RAC issues **Review Results Letter** to provider (does NOT include $$$ or appeal rights)

If no findings STOP

Connolly RAC has posted 1st set of new issues/automated

- Blood transfusions -1 unit per session regardless of the # of units transfused on that date of service. (36430, 36440, 36450, 36455)
- Untimed codes. Unit of 1 for untimed codes. (EX: PT initial eval)
- IV Hydration Therapy. 90760/96360. Maximum # of units 1/DOS
- Bronchoscopy services. 36125,31628, 31629. Max units 1/ DOS
- Once in a lifetime procedures. By virtue of the description of the CPT code, providers may only perform these codes 1x per lifetime.
- Pediatric codes exceeding age parameters. Newborn and pediatric CPT codes billed or applied to patients who exceed the age limit defined by the CPT code.
- J2505 (injection, pegfilgrastim, 6 mg) By definition, J2505 represents 6 mg per unit. Providers should bill the code at 1 unit per pt per DOS.
- NOTE: Excluding claims with Modifier 59!! (Bronc,blood, Hydration, untimed) DANGER

Areas of shared risk – Pt Status

- Providers order services…hospitals bill services.
- Providers lack understanding of hospital documentation rules – including pt status.
- Pt status (inpt, OBS, outpt in a bed receiving treatment, extended recovery, ER, SDS) is a payer requirement for ALL payers.
- IT DOES NOT IMPACT THE TYPE OF CARE THE PT RECEIVES.

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…"**

OBS 2006 Fed Reg Info

- **Observation** is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
- *Note: No significant 2007, 08 or 09 reg changes*

Medicare Rules for Inpatients

- Pays only for medically necessary care (now being closely scrutinized… Medicare RACs & Medicaid MICs)
- Care at the appropriate site/setting and level for today's need
- *NOTE: If the hospital bills an surgical inpt and it is denied, there is no ability to rebill the surgical codes as an outpt; just ancillary services, primari*ly. Provider impact = not automatic recoupment at this time.

Focused areas of risk

- Hospital bills one status, provider bills a different one. (Inpt vs obs) Who is right?

  *Hint: will reject during data mining and require audit to determine appropriate setting.

  * Hint: Compare hospital status with billing company if in doubt.

- Providers bill hospital based services as office based. Hospital based has a reduced payment. (1500 form/837P place of service issues)

Risk: place of service

- “Medicare contractors have overpaid physicians an estimated $20.2M between Jan 05 and Dec 06 for incorrect place of service codes, per HHS posted 7-10-09
- Physicians are paid a higher Medicare Part B rate if they perform services in their office vs hospitals or ASC.
- OIG sampled 150 claims and found that only 21 were correctly coded. Sample was from 850,000 with same service/same day.”

CMS website, update 6-26-09 Automatic recoupment

- CMS is often asked about other claim types that may be affected by a full inpt denial and if the RAC will deny other claim types associated with the inpt stay, such as physician E&M services. (Hint: Like H&P, daily visit, D/C)

- At this time the RAC will not automatically deny claims that are associated with a full inpt denial. However, these claims may be reviewed individually and there may be reviewed individually and there may be a need to fully/partially adjust the claim based on the documentation submitted.

More Updates 9-06-08 Commander Casey, CMS

Thought: It is imperative that we partner with our providers to reduce risk and improve the story in the record.

However the current RAC program, unfortunately, does not work to build this collaberative environment.

Separate E&M/office visit from E&M/associated with hospital stays.

Q: *If the hospital is denied its full inpt stay, are the physician's H&P and visits also denied? Same question as to the 3 day qualifying*.

A: It is possible the RAC may recoup part B that are also billed but it is not automatic.

Medical Record Limits FY 2009

- Inpt hospital, IRF, SNF, Hospice

10% of aver monthly Medicare claims (max of 200) per 45 days

- Other Part A billers (outpt hospital, HH)

1% of aver monthly Medicare services (max of 200) per 45 days

PENDING FINAL: Move from 200 per NPI # to 200 per TAX ID # /Office on FinMtg 10-08 or per GNYHA 8-09, per campus

- Physicians

Solo: 10 per 45 days

2-5: 20 per 45 days

6-15: 30 per 45 days

Large grp 16+: 50 per 45 days

- Other Part B (DME, Lab)

1% of aver monthly Medicare Services per 45 days.

Note: Per CMS & GNYHA 8-09,

The RAC may only ask for 1 request every 45 days, regardless if they used their record limit. But this could change.

Stop the madness

IDEA: Once a potential error has been identified, work directly with the MAC/FI to discuss a repayment of like issues. The RAC can continue to review the same item every 45 days. Self disclosure on issues back to 10-07 will reduce the cost of record copying & internal assessment.

Ensure a complete record of all self disclosed or rebilled accts are kept as the original claim should be excluded from all data mining..

Update on N432-RAC adjustment

- Queried Cdr Casey if there were different codes to separate different activity that could be represented by N 432:
  - Under payment
  - Over payment
  - Interest accrued
  - Interest paid

  Reply: There is one code for both underpayments and overpayments. (? Interest) 2-14-09

  PS N102 or 56900 for recoupments due to no records returned/technical denial. (SOW, pg 20)

Sample letter communication

- *Dear pt*
- *As part of ABC hospital's (or Dr Peter's) commitment to compliance, we are continuously auditing to ensure accuracy and adherence to the Medicare regulations.*
- *On (date), Medicare and Dr Peter 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 business office. We apologize for any confusion this may have caused.*
- *Thank you for allowing Dr Peter to serve your health care needs.*

Auditing hints – Proactive –office as well as partner/hospitals

- With all online documentation or an EMR, print the documentation and audit. Note variances in the pt story.
- RAC will receive records faxed, disc or mailed. All will be hardcopy auditing at this time.
- Close watch bell curves per specialty. Why are you being 'looked at?"
- All variances should be discussed with a focus on moving forward as well as looking back!
- If appealing, still determine potential patient, partner and practice impact – as at any time the appeal process may end.

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Thanks for joining us!

Free info line available!