RACs: Strategies to Reduce Your Risk and Successfully Appeal Payment Denials

Updated May 2010

Erin Trompeter, Editor
Nina Youngstrom, Managing Editor, Report on Medicare Compliance
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Introduction

After CMS launched the Recovery Audit Contractor (RAC) program in March 2009 across all 50 states, many of the auditors’ specific targets have come to light. Hospitals shouldn’t assume that RACs will automatically go after complex topics like medical necessity, since contractors also will focus on obvious “no-brainer” issues, such as claims for two or more of the same organ removed in the same patient. Plus, amid all the focus on more common risk areas, hospitals should not lose sight of the importance of finding errors within their own organizations through audits.

Hospitals can expect to see a greater expansion of RAC audits in the future. That’s because health reform legislation enacted in March 2010 expands the RAC program to include audits of Medicaid claims. States will be required to hire RACs to identify and recoup under- and overpayments as well.

In the pages that follow, you’ll read about current RAC targets and those likely in the future, as well as how hospitals can respond.
High-Risk and Target Areas

CMS Official: Site-of-Service Errors Are Top Risk; Expect Cardiac Status Guidelines

Medicare contractors are hunting down hospital payment errors stemming from the determination that services could have been provided in a less intensive setting (inpatient versus outpatient), George Mills, the director of CMS’s provider compliance group, told AIS in spring 2009. This medical-necessity problem is perhaps the foremost program-integrity challenge confronting hospitals, Mills says. “The big issue is going to be this site-of-service issue because the world of medicine is changing, and more and more services can be effectively provided on an outpatient basis,” he adds. “As technology changes, this will be the ongoing trend. It gets down to Medicare instructions and whether it’s reasonable and necessary for patients to be in an acute setting — whether they need that intense level of care.”

Both regular contractors — fiscal intermediaries (FIs) and Medicare administrative contractors (MACs) — and recovery audit contractors (RACs) can conduct site-of-service reviews, Mills notes.

A prime example is pacemaker maintenance. The demonstration RACs have denied short inpatient stays for pacemaker maintenance that could have been performed on an outpatient basis, Mills says. Some hospitals would rebut, saying the patient was very sick and required inpatient care. “But when we looked at the medical records,” he says, there was often evidence to the contrary. For example, the physician documented that the surgery could be performed on an outpatient basis. Or the medical record stated something like “schedule this patient for May 26 because his daughter will arrive on a flight from Detroit the day before.” That’s not grounds for admission. “You have to show it was an emergency issue and that patients needed this level of care,” Mills says. “Clearly, you can’t argue [the procedure] was a medical emergency” if it can be rescheduled to arrange family support.

Patients obviously are cleared for inpatient admissions when procedures are on CMS’s inpatient-only list. But other procedures fall into a gray area, and the numbers will grow with medical advances. “[Procedures] can be inpatient or outpatient, depending on the nature or condition of the person,” Mills says. CMS is trying to provide more assistance to hospitals in this area. “We have been working collaboratively with the medical community,” particularly in the cardiac arena, on clarifying site-of-service issues. For example, the Heart Rhythm Society will release guidelines on which procedures are more appropriate for inpatient versus outpatient settings, Mills explains.

CMS program-integrity officials are exploring new strategies for reducing medically unnecessary care. For example, “we have been talking with private payers to try to get an idea of how they do medical review,” Mills says. “Medicare does no prior authorizations, which are the No. 1 tool in the private sector.” It looks like CMS will soon wade into the prior-authorization arena, however. The administration’s budget for fiscal year 2010 includes funding to hire radiology benefit managers to pre-screen radiology services. But obstacles remain. Mills says that in his talks with private insurers, “they were flabbergasted” by the sheer volume of services Medicare has to manage compared to their own. There were over 44 million Medicare
beneficiaries in 2008; a health plan may have three to five million enrollees. “And our populations are very different” (i.e., Medicare patients generally are sicker), he says.

Mills is the first head of the provider-compliance group, which was created in late 2008 when CMS realized that the crusade against Medicare waste, fraud and abuse was too expansive for one office. So two camps work in tandem: the program-integrity group headed by Kim Brandt, and the provider-compliance group headed by Mills. The program-integrity group is responsible primarily for detecting and preventing Medicare fraud with the help of its program safeguard contractors, which will morph into zone program integrity contractors. The provider-compliance group focuses on error and overpayment identification, with responsibility for RACs; medical review; comprehensive error rate testing (CERT), which identifies the Medicare payment error rate; payment error rate measurement, which calculates the Medicaid error rate; and data analysis to detect suspected vulnerabilities.

CMS contractors play big roles in all of these operations. For example, MAC medical-review units can review any claim at any time for any reason. MACs can perform prepayment medical review, probe samples or post-payment reviews or use statistically valid extrapolations, Mills says. “RACs can do post-payment medical review or statistically valid extrapolations.” And MACs and RACs can review claims to determine whether the site of service was appropriate (e.g., whether the inpatient could have been treated in observation).

**Documentation Problems Pervasive**

Mills says that inadequate documentation continues to be the universal source of claims denials. “It’s probably the No. 1 reason for errors,” he says. “I am kind of shocked, given the litigious nature of the country, that medical records are not there or that there is incomplete documentation.” There are many different flaws, including missing discharge notes, absent diagnostic test results and a lack of physician signatures. CMS’s CERT contractor details documentation problems in its annual fee-for-service error rate reports. The demonstration RACs also identified lack of documentation as a major source of claims denials. “We always educate people that there must be complete documentation,” he says. The CMS mantra: If it isn’t documented, it didn’t happen. In the RAC arena, Mills says two of the RACs — HealthDataInsights, Inc. and Connolly Consulting — “will probably do collections in June or July [2009]” for overpayments identified by automated reviews. The other two RACs — CGI Technologies and Solutions, Inc., and Diversified Collection Services — will start recouping shortly thereafter. CMS is already reviewing RACs’ audit proposals; RACs are not allowed to audit without getting clearance from the CMS “new issues review board.”

RACs are kicking off the national program with more obvious reviews. “At least at the start, we will have the RACs focus on no-brainer, black-and-white issues” — in which errors are apparent “on the face of the claim” — rather than more complex topics like medical necessity, he says. Blatant errors include improper discharge disposition coding, ambulance transports during inpatient stays and claims for two or more of the same procedures on the same patient (e.g., three gallbladder removals).

**“Stay Tuned”: PEPPER Will Return**

CMS plans to continue the Program for Evaluating Payment Patterns Electronic Report (PEPPER), a free data tool to identify potential billing errors. “We are jumping through bureaucratic hoops,” Mills says. “The contracting process is taking longer than expected.” PEPPER was provided to hospitals quarterly to help their compliance auditing. It was part of CMS’s Hospital
Payment Monitoring Program (HPMP), a vehicle to reduce inpatient payment errors. Medicare quality improvement organizations, which had contracts to operate HPMP in their respective states, distributed PEPPER, which reported to each hospital where it stood in billing volumes for 13 risk areas compared to its peers.

Even though HPMP ended July 31, 2008, CMS decided to keep the PEPPER data flowing — first until Jan. 31, 2009, and then indefinitely — because the data promote hospital self-policing. But hospitals are still waiting for PEPPER to resume. “We are going to do it. It’s just a question of when,” Mills says. “Stay tuned.”

When it killed HPMP, CMS shifted more medical review to fiscal intermediaries and Medicare administrative carriers. “Each contractor looks at activities that are unique to their area and develops a medical-review strategy to address those issues,” Mills says. Some are national and some are local. For example, on the Part B side, contractors in sun-kissed Florida are reviewing claims for skin lesions, but the same can’t be said for their counterparts in Oklahoma or North Dakota. Similarly, Florida and Louisiana have “a disproportionate share of community mental health centers,” so they are more likely to have FI/MAC scrutiny in those states.

The program-integrity and provider-compliance groups are collaborating on a project that should greatly increase CMS’s ability to manipulate data to identify suspicious billing patterns. In late September 2009, “we hope to have a dramatic leap in our capability,” he says. The computer project, called One PI (which stands for One Program Integrity), will meld data from all parts of Medicare (A, B, C and D) as well as Medicaid “to give us a complete view of beneficiary interaction with the program and, hopefully, do complex analytics on data.” CMS is already able to cross-check Part A and B claims and match Medicare and Medicaid claims in certain states (under the Medi-Medi pilot), “but not the rest,” Mills notes. One PI, he adds, will be the next big step forward.

**CMS: Half of Medicaid Audits Hit Hospitals; QIO Admission Necessity Can Be Overruled**

Hospitals are facing the brunt of CMS Medicaid audits, agency officials said July 15, 2009, at an “open-door forum.” So far, in the 17 states where Medicaid integrity contractors (MICs) are up and running, there are 500 audits under way — and 44% target hospitals, Robb Miller, director of field operations for CMS’s Medicaid Integrity Group, explained at the forum. As for the rest of the MIC audits, 29% focus on long-term care facilities, 21% on pharmacies and the remainder on a mix of physicians and other providers and suppliers.

“We are screening data for over half the country and will actively screen data for the whole country by the end of the year,” Miller said. “We will be operational in every state in the country” when 2009 comes to a close.

Medical-necessity decisions are open to challenge by MICs, even when hospital admissions were approved by Medicare quality improvement organizations (QIOs), said Jim Gorman, director of the Division of Fraud Research and Detection in the Medicaid Integrity Group. “The determination of medical necessity is a physician call, and you have your [QIO] look at it to make sure [the physician] is making the right decision. But at the end of the day in an audit, someone has to second-guess both of them, and if the [QIO] makes a mistake and the admission is not medically necessary, we will throw a flag on it,” he said in July 2009. However, he added that the state
Medicaid agency will have a chance to review MIC audit conclusions. “We expect resolution of any issue like this to be a collaborative process,” Gorman said. The medical necessity of hospital stays is slated to be a major focus of MICs and RACs, the way it was in the RAC pilot.

As part of their audits, MICs have the right to ask for an unlimited number of medical records, unlike recovery audit contractors (RACs), which face CMS-imposed caps. For now, the nature of the MIC audit will determine the number of records required, CMS said. “We don’t want to make massive medical-records requests unless it makes sense,” Miller said. CMS may never formalize a ceiling on the number of medical records that MICs can pull. “It may not be necessary,” Miller explained. “It could be that we will do more formal sampling and possibly extrapolate findings based on state administrative procedures.”

**CMS Weighs Standard on Age of Claims**

Similarly, CMS is reviewing whether to restrict the look-back period for MIC audits. In other words, what should the limit be on the age of claims subject to a MIC audit? RACs are not allowed to review claims that are more than three years old (and that were paid earlier than Oct. 1, 2007). At the moment, the MICs abide by the look-back period established by the state in which the audit is being conducted. For example, in New Jersey it’s two years. However, CMS is weighing a more uniform standard, a spokeswoman tells AIS.

CMS also is reconsidering the deadline given providers to submit medical records to MICs. While RACs give providers 45 days plus another 10 for potential lags in mail delivery, MICs abide by the state Medicaid agency’s time limit. However, CMS may change that as well so providers in all states have the same amount of time, and it might be 45 days. Providers are asked to pull medical records based on key patient identifiers, such as date of birth, date of service and Medicaid identification number, Miller said.

Very soon, CMS said, the Medicaid Integrity Group will flesh out a lot of these issues in seven or eight pages of answers to frequently asked questions, said Paul Miner, deputy director of the Medicaid Integrity Group. They will be posted on the Medicaid Integrity Group Web site at www.cms.hhs.gov/medicaidintegrityprogram. The Web site will also list procurement timelines “so there’s a better sense when contractors are coming on line” and the nature of audits they will conduct, he said.

CMS works with states in the pursuit of Medicaid overpayments. To ensure they understand Medicaid policies and procedures, MICs are required to work with state Medicaid agencies. After completing an audit, MICs send the state a draft audit report for feedback. Revisions are made in response to state comments. “We then share a second [draft audit report], and when issues are resolved, we take the final report to the state,” Miller explained. State Medicaid agencies do the actual overpayment recovery, the same way Medicare claims-processing contractors (e.g., fiscal intermediaries) recoup overpayments identified by RACs. Providers then follow whatever appeals procedures exist in the state.

The audits are driven in part by data mining and analysis conducted by the Division of Fraud Research and Detection. “We have identified a large number of suspect overpayments and commenced audits in half the country,” Gorman said. By running hundreds of algorithms against large amounts of data from Medicare’s data warehouse (using only provider identifiers), the Medicaid researchers look for signs that something is amiss. For example, he said, were services allowable? Were they unbundled? Is it an “impossible” service or drug quantity? Or was it inappropriate for drug A to be administered with drug B? “We identify providers who are egregious and who we
think require a second look," Gorman said. However, the data doesn’t always mean the provider overcharged Medicaid. Sometimes the data are "corrupt," for example, or what seemed like double payments to the provider turned out to be the state’s failure to process the adjustment.

**Hospital Runs Mock Audit**

Meridian Health System in Neptune, N.J., will start ramping up its internal Medicaid audits to prepare for the arrival of the MICs, says Compliance Officer Peter Hughes. “This is basically RAC for Medicaid,” he notes. “We’ll piggyback off what we do for the RAC.” But he’s alarmed by the volume of medical records that RACs and MICs will audit and the relative speed with which they must be submitted. “It’s a tremendous burden on providers,” he says. It doesn’t look like CMS is being all that realistic about what hospitals can accomplish. For example, Meridian ran a mock RAC audit process to test response times, and “it was a real struggle” to meet them, Hughes told AIS in July 2009.

As part of the mock RAC audit, he sent out requests for 75 medical records to different entities in his health system. “You don’t just grab charts, copy them and put them in a box,” he says. “You review [medical records] before they go out. You make sure they are complete and accurate so you are in a better position to appeal in case they are disallowed.” And reviewing medical records is a matter of both substance (e.g., Were services provided as charged, medically necessary, coded properly, covered, reasonable?) and style (e.g., Are all the relevant rest results included? Is the physician’s signature on the right forms? Is the patient’s name on every page, front and back?)

Meridian barely finished its review in time for the 45-day deadline and is still evaluating whether all “t”s were crossed and “i”s were dotted. And if CMS does not implement a uniform production deadline for the MICs, the medical-record deadline could be shorter in New Jersey. “It could kill us,” he says.

Meanwhile, Hughes says Meridian will intensify its Medicaid audits of high-risk areas identified by the pilot RACs and OIG. A prime target is the medical necessity of hospital admissions (particularly short stays and certain DRGs, such as chest pain and other cardiac DRGs). “That’s where the big dollars are,” he notes. If charts lack adequate documentation, the hospital will ask attending physicians if there is additional information available to support the admission to ensure accuracy and thoroughness (but only, of course, if it is true and the post-hoc nature of the documentation is made clear). Perhaps, for example, if there were uncharted complications, such as diabetes, that would explain why a patient was admitted.

CMS plans to tell providers when audit findings are negative (i.e., there is no overpayment). Miller said it has become apparent that providers need a definitive answer on the outcome of the audit, whether positive or negative. “You have a right to know when there will be no further actions taking place,” he said. ♦

**OIG Data Reveal Excessive Billing for Services Done by Unqualified Nonphysicians**

For the first time, the HHS Office of Inspector General has determined that a significant number of services billed by certain physicians are performed by unqualified nonphysicians.

In an innovative study that recovery audit contractors (RACs) may replicate, OIG found that, during the first quarter of 2007, when physicians billed for more than 24 hours of services in a day,
51% of the services were performed by nonphysicians. Unqualified nonphysicians performed 21% of those services, including invasive procedures (e.g., surgery, chemotherapy), according to the report, which was posted on the OIG Web site on Aug. 5, 2009. Medicare allows physicians to bill for more than 24 hours worth of services in a day to capture charges for legitimate work performed by nonphysicians (e.g., physician assistants) incident to the physician's professional services, but focusing on this subset helped OIG quantify a compliance and quality risk stemming from unlicensed or untrained nonphysicians.

“This report should be a wake-up call,” says Jean Acevedo, a former practice manager and now a physician coding and billing consultant in Florida. It wasn’t easy to identify this problem because CMS has no modifier to distinguish physician services from nonphysician services provided incident to the physician. (Both appear on the claim under the physician’s national provider identifier.) For this report, OIG had to design a clever method for flagging incident-to services and then determine whether the nonphysicians who provided them were qualified. But now OIG has paved the way for RACs to follow suit, and given the findings, it’s a sure bet they will, Acevedo says.

What heightens the risk for physicians is the recent trend toward Medicare contractors adding qualifications to local coverage decisions (LCDs) for physicians and nonphysicians, she says. That makes it an overpayment or potential false claim to bill for a service subject to an LCD if it were provided by a physician or nonphysician who lacked credentials that the LCD required to perform the service. Nonphysicians include medical assistants and nurses as well as nonphysician practitioners (NPPs), such as physician assistants, who have advanced training.

Acevedo is baffled by CMS’s refusal to implement a modifier for incident-to services since Medicare pays 100% of the fee schedule for services whether they’re performed by the physician or incident to the physician as long as specific conditions are met (e.g., direct supervision). OIG advocates creation of a modifier because there is no way for CMS to look at a claim and distinguish between services personally performed by a physician and services performed by a nonphysician, she says. But CMS demurs, saying it would be “operationally difficult” for physicians to add a modifier for incident-to services because they are “often shared by physicians and staff.” CMS said that muddies the waters of what was personally performed by the physician versus the nonphysician. But Acevedo says that’s hooey. Since when, she says, has the hassle factor dissuaded CMS from pursuing its goals? And it’s not true that services are shared, Acevedo contends. The point of the incident-to designation is that qualified nonphysicians perform services independently as long as a physician is around to consult with or intervene if necessary. “There needs to be a modifier,” she says. “It makes the doctor stop and think whether the service was really performed by a competent staff member pursuant to the incident-to rules.”

To figure out when services billed by physicians were actually performed by nonphysicians, OIG’s Office of Evaluation and Inspections identified all days during the first quarter of 2007 on which Medicare allowed billing for more than 24 hours of physician work time. “We randomly selected 250 of these ‘physician-day’ combinations and requested that the physicians identify who performed each service that Medicare allowed on the selected day(s),” the report stated. Physicians were then asked to submit credentials for nonphysicians who worked on those days. OIG’s nurse reviewers evaluated whether nonphysicians were qualified to perform the services that they provided and that were billed by the physicians, relevant Medicare requirements, state laws and regulations, and the nurses’ own professional judgment.
OIG Fears Broader Problems

The results: Medicare shelled out $85 million for about 990,000 services that nonphysicians personally performed during the first three months of 2007. Nonphysicians performed almost two-thirds of the invasive services for which Medicare paid physicians. The invasive services included venipuncture, cataract surgery and extensive foot surgery. Nonphysicians also performed 46% of the noninvasive services, including rehab, ophthalmology and evaluation and management.

Were the nonphysicians qualified? In many cases, no. “Nonphysicians with no verifiable qualifications performed 25 percent of the services….Nonphysicians who lacked the necessary training performed another 25 percent of the services,” OIG stated. Seven percent of the invasive services were performed by nonphysicians with inappropriate qualifications. Ultimately, Medicare paid $12.6 million for about $210,000 in services performed by unqualified nonphysicians during this three-month period, according to the report (09-06-00430).

The 24-hour approach is just the tip of the iceberg. “We are concerned about the potential scale of this problem,” OIG said in the report. “Physicians who bill Medicare for fewer than 24 hours of services in a day might also bill for ‘incident to’ services performed by unqualified nonphysicians.”

RACs may seize on that notion, especially since OIG reports are a CMS-approved source of RAC audits. Acevedo says even without the modifier, RACs can easily identify where services are rendered incident-to. They identify a specific service on which to focus, “and get a data dump of all claims data so they know that on a given day, Dr. Smith billed all these codes, and behind these codes are time factors” indicating Dr. Smith billed 24 or more hours of services in a day. “That means clearly some of them were performed by someone else,” she notes. Rehab therapy in particular is an area fraught with risk, says Acevedo, president of Acevedo Consulting in Delray Beach, Fla. In fact, OIG found that 87% of the claims in the OIG study were performed by nonphysicians.

Tips to Avoid Nonphysician Noncompliance

Here are Acevedo’s tips for incident-to compliance:

- Validate that employees are qualified to provide the services they perform.
- Make sure incident-to coverage criteria are met when physicians bill for services provided by nonphysicians. Medicare requires the physician to have previously treated the patient for the same condition before the nonphysician can step in; the physician must be present in the office suite at the time services are rendered; and the physician must provide direct supervision.
- Review your Medicare contractor’s LCDs and determine if your practice meets the credentialing and/or licensure requirements. In particular, “there are more and more of these as they relate to diagnostic services that also now have requirements for qualifications of physicians and technical staff providing the services,” Acevedo says. For example, First Coast Services Options, the Medicare administrative contractor for Florida, has several LCDs that spell out certification requirements (e.g., for carotid ultrasounds).

In addition to the need for a modifier, OIG recommends that CMS seek changes to the incident-to rule. Only licensed physicians or trained and certified and/or licensed nonphysicians should perform services incident-to the billing physician, the report states. Also, CMS should
deal with claims identified that (1) were performed by nonphysicians but did not meet incident-to criteria, and (2) were for rehab therapy but performed by nonphysicians who lacked therapy training. CMS agreed with the suggestions, except for the modifier. The agency said it would study the operational implications of a modifier for incident-to services.

Interventional Radiology Errors Are Pervasive, May Attract RAC, MAC Scrutiny

With its high error rate, interventional radiology coding and billing is ripe for greater compliance oversight — especially as recovery audit contractors (RACs) and other Medicare contractors intensify their reviews.

But with the steady stream of technology advances and intricate anatomical knowledge necessary for coding, it takes more than the usual effort and oversight to ensure claims integrity in this area, experts said in September 2009.

Fifty percent of interventional radiology claims have at least one coding error, according to data from 750 hospitals audited by interventional radiologist David Zielske over the past nine years. “The financial impact varies, but it can be significant,” he says, whether it results in undercoding or overcoding. “If you have 10 correct codes on a claim but two other codes are incorrect, there may be a significant financial impact for the patient, hospital and payer.”

Interventional radiologists use imaging to perform procedures, such as angioplasty and stent placement, without having to do invasive surgery. This is a very complicated area, says Wendy Trout, compliance officer for WellSpan Health in York, Pa., who had been assured by hospital coders that they understood the nuances of interventional radiology and then found that coding needed improvement. “One thing that was really interesting about this area was the way the environment has seemed to change and how important it is to stay on top of things. It isn’t as simple as reading a code book and assigning a code. You have to follow what is going on in the industry and stay on top of interpretations.”

The newer crop of smaller devices allow interventional radiologists to get into vessels they couldn’t access before. “It’s a very cutting-edge field with a lot of new technology,” says Zielske, CEO of ZHealth Publishing, an educational and auditing firm. For example, some physicians will put in the chart that they did a “Silverhawk” or used a diamondback device, which means they performed an atherectomy with those particular devices. Physicians are required to document the procedure they performed — in this case, an atherectomy, which involves removal of blockages from arteries and corresponds to a specific set of CPT codes, he says.

There is potential for coding errors in interventional radiology due to lack of medical necessity or documentation or billing snafus. With documentation, for example, a common problem occurs when physicians use the terms “biopsy” and “fine needle aspiration” interchangeably. A physician usually performs one or the other, Zielske says, but the codes for these procedures have different CPT descriptions and implications. Sometimes the physician calls the procedure a biopsy in one section of the chart and a fine-needle aspiration in another, or uses both terms in the same sentence. “Once in a while, you perform both on the same patient at the same setting,” Zielske says. This needs to be appropriately documented.

In terms of medical necessity, there is increasing scrutiny of repeat angiography. For example, when patients have an initial diagnostic catheter-based angiography and consequently are admit-
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But Zielske emphasizes there are legitimate reasons to perform a complete, new diagnostic angiogram in a short time frame. For example, if the interventional radiologist places an iliac stent and a week later the patient complains of increased leg pain and ischemic toes, “you may have to repeat the angiogram,” Zielske notes. However, if the medical necessity can’t be justified, it can’t be billed. Technologists might not realize this and enter charges for the angiogram, which are then billed inappropriately. Guiding shots or roadmapping images used to assist in measurement location or confirmation of lesion for angioplasty or stent placement are considered part of that intervention and aren’t separately billable as a diagnostic angiogram.

Coding is perhaps the trickiest part because coders must understand advanced anatomy, apply coding guidelines and medical-necessity criteria, and grasp bundling rules, he says. Hospitals will improve their compliance dramatically if they hire certified interventional radiology cardiovascular coders (CIRCCs), Zielske says, which is a brand-new designation offered through the American Academy of Professional Coders. It was created for coders and technologists because CPT codes may be entered by both.

One challenge coders face is bundling and unbundling issues relevant to interventional radiology. Some codes are separate, component codes, while others are comprehensive, which means they include components that must be bundled into the comprehensive codes. Some component codes include multiple components. For example, Zielske says, the code for fibroid embolization (CPT 37210) includes all catheter placements, imaging and interventions pertinent to the area of treatment, which is uterine fibroid treatment. The code for transjugular intrahepatic portosystemic shunt, also known as TIPS (CPT 37182), includes catheter placements, imaging and interventions pertinent to its area of treatment, which is for creation of a portosystemic shunt in the liver. However, separate procedures performed at the same time would not necessarily be bundled. An example would be performing a gastroesophageal variceal embolization during TIPS, which is separately billable.

Three Tips to Improve Compliance

Coders also must keep up with new technology codes ("T" codes) and Medicare-specific HCPCS codes that supersede CPT codes. T codes can change every six months, while CPT codes are updated every year, he says. “Coding is dynamic. Guidelines may change, published rules may change, society recommendations may change and the codes themselves may change,” he says. Hospitals must ensure their coders have access to the latest coding materials, he notes.

What happens in the billing department also poses compliance risks. “Coders do their work and everyone assumes what they coded actually got on the bill, but this isn’t always the case,” Zielske says. Billers may remove codes that hit a scrubber edit because they want to push the claim through. For example, Medicare correct coding initiative (CCI) edits will kick in if the claim has more than one of three types of selective artery placements: first order selective artery placement (CPT 36215), second order selective artery placement (CPT 36216) and third order selective
artery placement (CPT 36217). As a catheter is advanced into a vascular family, the first level of selectivity is considered first order. If the catheter is advanced further, it may become a second order selective catheter placement. In this case, the first order is included and can’t be separately billed, which means the 59 modifier shouldn’t be applied. However, if the physician selects vessels in two separate vascular families, it would be appropriate to attach a 59 modifier to one of these catheter placements. It may take a person with subspecialty coding expertise to grasp these subtleties. Zielske says.

Here are Zielske’s tips for reducing interventional radiology billing errors:

1. Make sure procedures are coded the same way even when performed by different specialists. For example, cardiologists, interventional radiologists and vascular surgeons all may place renal stents percutaneously. Code assignment should be driven by the procedure, not the type of specialist. To ensure compliance with this concept, Zielske suggests identifying all the locations — including the operating room, cardiac cath lab, dialysis lab, heart center, endovascular surgery center, interventional radiology center — where a particular procedure could be performed. Then determine if the procedures are being coded exactly the same way when performed using the same method.

2. Have someone knowledgeable do claims reconciliation. That means comparing the original codes, which are based on documentation, to the payment the hospital actually received according to the remittance advice.

3. Ensure hospital and physician codes for the same procedure match. “With the presence of Medicare administrative contractors (MACs), this may quickly become an issue if there is a discrepancy between what the hospital and physician bills,” Zielske says.

**RACs Focus on Riskiest Services, but Hospitals Should ID Their Vulnerabilities**

Recovery audit contractors (RACs) won’t bother with a complex review unless they’re sure it’s an area that’s ripe for recoupment, according to the top RAC official at CMS.

“We don’t want to have RACs waste their time reviewing claims where there are no errors. We want them to review claims with a high probability of error,” Connie Leonard, director of the CMS Division of Recovery Audit Operations, said Oct. 5, 2009, at the Fraud and Compliance Forum in Baltimore. “RACs do not do random reviews.” Audit targets are selected based on things like data mining, aberrant billing patterns and the experience of RAC auditors, who are often former Medicare contractor auditors, Leonard said at the forum, which was co-sponsored by the Health Care Compliance Assn. and American Health Lawyers Assn.

Complex reviews require RACs to scrutinize medical records to determine whether a service was, for example, medically necessary for the site of service where it was performed. RACs also perform automated reviews for obvious billing and coding errors (e.g., two appendectomies on the same person).

RACs won’t be allowed to scrutinize medical necessity and do other complex reviews in any state until they first conduct automated reviews and DRG validations there, Leonard said in an October 2009 follow-up interview with AIS. “The RAC needs to establish a professional relationship and trust with the provider community,” she explained. “The RAC must prove to the provider community that it understands Medicare and can make accurate determinations.”
For example, do auditors for the RACs understand the local coverage determinations (LCD) in effect for that state or region for the relevant time period? Are they following CMS guidelines and coverage requirements? CMS must be satisfied the answer is a resounding “yes,” she said.

To reinforce providers’ confidence in RAC knowledge of subtle medical-necessity issues, CMS’s “new issues review board” must approve every proposed RAC medical-necessity audit before the RAC can proceed. The review board includes CMS policy and coverage staff and RAC officials.

Meanwhile, the RAC march is making its way across America. CMS and its RACs have conducted provider outreach in all states except Maryland, Virginia and Puerto Rico, which makes them the only places where hospitals are safe from RAC audits for now. CMS has promised that RAC audits won’t begin in any state that has not held one of these educational sessions, Leonard said. The Puerto Rico outreach meetings will be held on Oct. 23, 2009, the Maryland session on Oct. 28, 2009, and the Virginia session the week of Oct. 12, 2009.

Leonard says hospitals in about one-third of states will receive some kind of correspondence from RACs by Jan. 1, 2010. Hospitals may get a reprieve if a state or region is in the middle of a transition from a fiscal intermediary and carrier to a Medicare administrative contractor.

RACs are paid by CMS only after they recoup money from providers stemming from payment errors. Contingency fees do not occur when payments are identified. Although RACs receive the bounty for identifying underpayments as well as overpayments, 96% of the errors detected during the three-year RAC demonstration were overpayments. But CMS is receptive to provider arguments of underpayments, Leonard said, as long as providers don’t swamp RACs with data about purported underpayments. “Providers may share underpayment ideas with their state associations, which may share them with the RACs,” Leonard said. However, she said, “CMS cannot guarantee that a RAC will review the issues.” During the demonstration, some associations showed underpayment areas to the RAC. The RAC investigated the underpayments. “Some turned out to be valid, and some did not,” Leonard said.

**Don’t Get Tunnel Vision on Risk Areas**

Now that RACs are unveiling audit targets on their Web sites, providers should determine whether they have vulnerability in these areas. But don’t get tunnel vision about the RAC topics. It’s important to look at many risk areas and at your hospital’s own idiosyncratic billing errors, says Charlene Nutter, director of audit/compliance services for Quality Management Consulting Group, Ltd. in Columbus, Ohio.

In the numerous hospital audits she has conducted, Nutter has found “billing variances in physical therapy” — a theme echoed by auditors around the country. For example, in Ohio, the fiscal intermediary’s local coverage decision makes it clear that pre-op evaluation for joint surgery is not covered. Yet hospital charts for joint surgery often show that pre-op evaluations are billed separately, Nutter said in October 2009. Even though “the LCD clearly says not to bill separately for pre-op evaluation” in connection with joint surgery, the lack of a Medicare edit to detect this charge means hospitals will get paid when they make this mistake, Nutter says. This area is ripe for Medicare recoupment.

The Ohio fiscal intermediary’s LCD also states that PT re-evaluations (CPT 97002), which are conducted 30 days following the initial evaluation and every 30 days after, cannot be billed if just performed as a matter of routine, she says. There must be documented medical necessity. And when two modalities, such as ultrasound and therapeutic exercise, are performed within the
same PT encounter, each modality must be reported by minutes, which translate into units. Even though each modality has its own CPT code, it is reported by units, and the number of minutes in the chart must correspond to the units on the claim. Nutter says that hospitals do a good job of accurately documenting the minutes, but something gets lost in translation, and “hospitals wind up overpaid” based on the number of units reported.

Look for Unexpected Errors

During her reviews, Nutter found a pervasive error with bronchoscopies, in addition to the RACs’ concern about this service, which relates to the number of bronchoscopies billed per patient per date of service. Some hospitals incorrectly apply the fluoroscopy CPT code, she says. When fluoroscopies are performed at the same time as bronchoscopies, they shouldn’t be billed separately. However, if hospitals incorrectly apply the 59 modifier to fluoroscopy, they will collect separate payments for both broncoscopy and fluoroscopy “even though CCI edits say you can’t bill fluoroscopy with bronchoscopy because it’s part of the service.” The reason this mistake happens is billers see the edit and figure if they stick on the modifier, the claim will get paid, Nutter says. “People have to clearly understand the use of modifier 59” and that it can only be used when there’s a significant, separately identifiable service that warrants another payment — not a service that is performed as part of another service.

Pharmacy and drug administration is another major RAC interest. For example, Neulasta (pegfilgrastim), a drug that reduces the risk of infection in cancer patients, was a big source of recoupment during the RAC demonstration and is in the national RACs’ first round of approved issues for automated reviews. “As auditors, we always look at Neulasta and have found the drug administration code is often wrong,” Nutter says. It’s common for Neulasta to be mistakenly reported with a chemotherapy drug administration code rather than a therapeutic administration code, which triggers an overpayment. The reason this happens, Nutter speculates, is that Neulasta is given in oncology clinics to help cancer patients. But it’s not a chemo agent so it shouldn’t be billed with a chemo administration code. The Ohio FI has an LCD that directs hospitals to use the therapeutic drug administration code for Neulasta rather than the chemotherapy drug administration code.

“If I were the RAC, I would look at drugs because they are high volume and high dollar,” Nutter says. “Often hospitals have a separate pharmacy software system,” and they try to configure that one system to accomplish everything: ordering, billing and dispensing drugs for nursing units. “But it can’t work that way. There have to be manual interventions. One software can’t do it that smoothly,” Nutter says.

Amid all the focus on RAC targets and common risk areas, hospitals should not lose sight of the importance of eyeing their own unique errors. All hospitals have their idiosyncrasies, which can be identified only through audits. “Often problems having to do with billing compliance are individualized per hospital,” Nutter says. For example, she discovered that one hospital was misplacing the decimal point when reporting units of Epogen and other erythropoiesis-stimulating agents (ESAs) administered to renal-disease patients for anemia management. Recently, CMS implemented a requirement that hospitals must report a patient’s hemoglobin and hematocrit levels in order to potentially get paid for doses of ESA drugs. The reason, CMS said, is to establish the medical necessity for the ESAs. Only patients with certain levels of hemoglobin and hematocrit are eligible for the expensive ESA drugs.
During an audit at one hospital, Nutter found that the patients did not actually meet medical necessity for ESAs according to their hematocrit and hemoglobin levels. But the hospital was reporting the units incorrectly, which made it seem like the patients crossed the medical-necessity threshold. The value code was reported on the bill as 1.13 when it should have been 11.3.

Hospitals must ensure that documentation is carefully maintained in the medical records. That’s not always the case. When RACs request medical records, she suggests they first conduct a quality review of information before they submit it to make sure everything is available. “It may be that the person doing copying doesn’t have any idea what the big picture is. Its could be a copy clerk is just doing his job and doesn’t realize that there is more [documentation],” Nutter says. “There has to be education of all of those involved in completing the RAC request.”

CMS Revises RAC Medical Records Cap; RACs Can Target One Area

CMS on Dec. 2, 2009, unveiled new caps on the number of medical records that recovery audit contractors (RACs) can demand from providers and suppliers. Compliance experts said in December 2009 that they saw both good and bad in the new caps, which were set to take effect in March 2010.

According to the new policy, every year CMS will establish a cap on the medical records that can be requested every 45 days from each campus. CMS defines a “campus” as one or more separate facilities or practices under a single organizational umbrella, which depends on tax identification number (TIN) and ZIP code. The cap is based on the provider’s claims volume during the previous fiscal year.

Under the initial medical-records request policy, CMS varied the cap by provider size, type and structure, according to their national provider identifiers (NPIs). The maximum allowed for entities, such as hospitals and skilled nursing facilities, was 200 every 45 days.

“The new rule is a step forward and a step back,” says Brian Flood, national managing director of KPMG in Austin, Texas.

On the up side, the new policy should reduce the burden for some providers. “This will be helpful,” says Wendy Trout, director of corporate compliance for WellSpan Health in York, Pa. The RAC “will group all our claims together” for purposes of the cap, rather than having separate buckets for inpatient, outpatient and physicians.

On the down side, CMS says that the RAC record request doesn’t have to be proportionately divided among claim types. “For example, the RAC may request inpatient records up to the full limit even though the provider’s inpatient business may only be a small portion of their total claim volume,” CMS says. This is “disturbing,” says Flood a former Texas Medicaid inspector general. “This could result in the disparities we saw in the pilot where inpatient was selected disproportionately to other service/risk areas.” Also, Flood says the new policy allows RACs to exceed the cap on medical records demanded from providers. But RACs need CMS’s permission first and they have to wait until the second half of the fiscal year to ask.

More Demands for Multiple Locations

According to the new policy, limits will depend on a provider’s TIN and the first three numbers of the ZIP code where it is located. For example, CMS said in the new policy, “provider A has
TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes. Provider B has TIN 123456780 and is physically located in 12345 as well as 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.”

Flood envisions that providers like “provider B” will face more demands under the new caps. If you operate under a single TIN, he says, but do business in more than one ZIP code, each geographic location will be seen as separate. As a result, RACs can ask these providers for 300 records every 45 days and ask providers in two ZIP codes under one TIN for at least 600, Flood says.

Also, medical-record demands will be capped at 1% of all claims that a provider submitted the previous calendar year, divided into eight periods (45 days). “A provider’s limit will be applied across all claim types, including professional services,” CMS said. For example, if a health care system billed 50,000 inpatient claims, 75,000 outpatient claims, 20,000 SNF covered stays, 20,000 home health episodes of care, 250,000 physician claims, 10,000 inpatient rehab claims and 1,000 hospice claims — for a total of 426,000 claims — the RAC could request a maximum of 532.5 medical records every 45 days if CMS waived the cap in this case. ♦
Facing RACs: Strategies for Success

RAC Flow Charts Drive Coordination Among Relevant Departments

Denials management has taken on a whole new flavor with the advent of recovery audit contractors (RACs), pushing a larger segment of routine claims analysis to the compliance function. Traditionally, patient financial services and/or denials management departments address claims denials unless there is a disturbing pattern or program-integrity contractors are involved, occurrences that, until RACs came along, represented a fraction of the challenged claims. But RACs are a hybrid. Their volume of audits is much higher than the usual program-integrity contractor — CMS is allowing an unlimited number of RAC automated reviews and, for hospitals, 200 medical-records requests every 45 days. And “everyone is concerned that trends around incorrect payments could be construed as fraudulent billing practices and referred to law enforcement agencies,” said Ami Zumkhawala-Cook, corporate compliance officer for 326-bed Holy Spirit Health System in Camp Hill, Pa., in May 2009.

While that’s always the case with program-integrity contractors and Medicare claims processors, the RACs tap into a deeper well of fear, perhaps because they are paid only if they find errors. As a result, many hospitals have put the compliance department in charge of RAC management, and this requires coordinating the activities of other departments to ensure that audit and appeals processes run smoothly.

Several Departments Are Involved

For example, a RAC coordinator in Holy Spirit’s compliance department will coordinate the RAC response and keep track of RAC correspondence in a tracking log. Other departments will play key roles. Health information management (HIM) will produce medical records at the RAC’s request, patient financial services will rebill services after RAC denials (e.g., outpatient ancillary services when inpatient claims are denied), and denials management will organize appeals.

To help the departments think through their RAC tasks, Zumkhawala-Cook developed two flow charts that describe and connect them. One is for automated reviews and the other for complex reviews. Another chart, currently in the works, will break down the denials management process. “The flow charts are a way to initiate conversations about each other’s roles and responsibilities around managing the RAC audit process,” she says. “You can say that medical records handles medical records and denials management handles denials, but [it makes a difference to] visually connect the dots and paint the picture of the workflow,” she explains. “Because of the way the lines are drawn and boxes are situated, people start to see interdependences.”

Though it’s normal for people and departments to concentrate on their own issues and set their own priorities, that mind-set has contributed to the confounding problem of silos, which can hinder compliance. Time constraints may continue to perpetuate silos somewhat, but “even if we continue so work in silos,” at least the flow chart helps people “know where the doors are,” Zumkhawala-Cook says.
She thinks RACs will remain a compliance priority until denials management and case managers gain more experience with medical necessity. One of the reasons RACs emerged as a compliance issue was that “many organizations don’t have a lot of experience fighting medical-necessity denials from Medicare, especially on the inpatient side,” Zumkhawala-Cook says. While managed care payers place nurses on hospital med-surg floors to monitor in real time the necessity of admissions and continued stays, Medicare does not have the resources for that level of scrutiny, she notes. So CMS emphasizes post-payment reviews of medical necessity, which means overpayment determinations after hospitals have already provided expensive services. That’s why the RACs have pursued medical necessity so fiercely, she says.

Eventually, as providers come to accept RACs as part of the program-integrity landscape, responsibility for coordinating the RAC response may shift back to patient financial services.

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**Work Flow Process for Recovery Audit Contractor (RAC) — Complex Reviews**

Ami Zumkhawala-Cook, corporate compliance officer for Holy Spirit Health System in Camp Hill, Pa., developed this chart to help staff track and document the hospital’s RAC interactions.

### Compliance Role

AC = Audit Coordinator

#### START

- AC receives audit request
- AC enters audit information into tracking log
- AC requests copies of records from health information management (HIM) department
- AC awaits determination on chart review
- AC receives determination letter. Consider appeal if denied.
- Appeal decision needed?
  - **YES** AC logs denial, forwards to DC for appeal coordination.
  - **NO** AC enters “won” or “lost” and closes claim status

### HIM Role

HIM = Health Information Management

- HIM gathers records from departments and prepares copies.
- HIM mails records and enters date sent and tracking information into log.
- HIM notifies audit coordinator when copies have been mailed.

### Denials Management Role

DC = Denials Coordinator

- DC receives notice of claim denial and coordinates review.
- DC enters reasons not to appeal into tracking log and notifies AC

- Appeal?
  - **YES** DC oversees production of appeal letter, enters letter into tracking log and submits to AC
  - **NO**
and denials management, Zumkhawala-Cook says. Compliance would be called in for anomalies, she predicts. “Compliance is supposed to be checks and balances, so why do you want compliance directly managing a financial process? That’s why we are trying hard to have the finance division equipped to do what it is supposed to do — manage the dollar. Compliance is here to manage compliance.”

**How to Challenge Claims That Are Denied By CMS for Insufficient Documentation**

CMS’s program-integrity mantra — “if a service wasn’t documented, it wasn’t performed” — is not grounded in Medicare laws or regulations, so hospitals should consider appealing claims denied for insufficient documentation if they believe the services were provided, one lawyer advises.

That’s not merely an abstract idea. Minneapolis attorney David Glaser in spring 2009 made headway with administrative law judges (ALJs) by submitting evidence that services were provided even though they were not documented according to Medicare’s evaluation and management (E/M) documentation guidelines, which is the gold standard.

Glaser has prevailed in a number of E/M payment appeals when claims were denied because Medicare contractors said they didn’t pass muster with documentation guidelines. For example, Glaser had an oncologist-client whose Medicare carrier denied $3 million worth of the oncologist’s claims after an audit of 90 patients treated during a four-year period. The claims were rejected mostly because the oncologist didn’t sign the chemotherapy records. Without the oncologist’s signature, the carrier said, how could it be sure the oncologist was present when the chemo was provided? In response, Glaser says, “we gave the carrier an affidavit from the nurses that the doctor was always there, plus his appointment book showing his schedule.” That should have put the matter to rest, he says, but “the carrier kept after him.” However, when the oncologist got to the ALJ, the overpayment was reversed.

“I’m not saying ‘ignore the documentation guidelines,’ because I think the burden is on the provider to demonstrate they did the work. If it’s not in the documentation, it will be a harder burden to meet,” Glaser says. “But if you have a physician who has poor documentation, I don’t think you have a duty to refund the money unless you think they billed for services they didn’t do. When documentation is lacking, you should make an effort to determine whether the services were provided as billed (underdocumented) or coded at a level higher than billed (overcoded). Medicare only requires a refund if it has overpaid based on what was inaccurately billed.”

As Glaser argued before an ALJ in June 2009, the fact that in-person hearings before an ALJ exist is, by definition, support for the idea that providers should be able to supply alternate forms of support for their services (e.g., testimony, appointment books). “The reason for a hearing is to gather evidence, to say whether the work was done,” he says. “If it were all a question of looking at medical records, why would HHS have an ALJ?”

Glaser’s strategy could be valuable as recovery audit contractors and Medicaid integrity contractors launch audits nationally, and Medicare administrative contractors and fiscal intermediaries ramp up medical review. These entities are under pressure to recoup money for the cash-strapped federal government, especially with President Obama’s pledge to help fund health reform with fraud-and-abuse recoveries. Document-related payment errors account for a signifi-
significant percentage of claims denials, according to the RAC pilot and the annual Medicare fee-for-service improper payment report.

Glaser has been able to fend off a Department of Justice (DOJ) investigation by resisting the government’s premise that an absence of conventional documentation is tantamount to no service being performed. “I had a fraud investigation where the government’s initial position was that ‘it was not written so [the service] was not done.’ They were going to use that standard” in pursuing the false claims case against his client, Glaser says. A whistle-blower had filed the lawsuit, and the government, after a preliminary investigation, contended that documentation was insufficient and therefore the provider should cut the government a check. “We said ‘no’ and the case went away,” Glaser says. DOJ refused to intervene in the whistle-blower’s case, and ultimately it was dismissed.

**Repeating It Doesn’t Make It Law**

“I haven’t heard CMS use the argument of ‘if it’s not documented, it’s not done’ in court. It’s not policy, it’s not a rule, and it shouldn’t be. It’s a dumb rule. But it’s been repeated so often that people start to live by it,” says Glaser, who is with the law firm of Fredrikson & Byron PA. “If it’s the law, [the government] should be able to point to it.” The closest dictates is the Social Security Act, which, in essence, states that no payments should be made to providers unless they furnish information to Medicare that enables it to determine the amount of reimbursement owed. But that key phrase — “furnish information” — does not specify medical records, Glaser says. And it’s fine that E/M documentation guidelines are de rigueur — and serve as a safe harbor, which means compliance with the documentation guidelines is a sure-fire way to get paid. But not falling perfectly inside them should not necessarily mean providers lose all reimbursement, Glaser says.

He says the “compliance oath” that providers should live by is to bill Medicare only for the services they perform, and if they really did the work, the payment should be forthcoming — even if documentation has to be provided by alternate means (e.g., nurse affidavits).

**Pay Attention to Documentation Requirements**

While many in the health law bar would agree with Glaser, some lawyers also strike a note of caution. “If the actual regulation, rather than subregulatory guidance, requires that there be certain items in the medical record, failure to have those items means that there is no basis for the claim, unless the provider or physician is planning on challenging the validity of the regulation,” says Washington, D.C., attorney Andy Ruskin, with the law firm of Morgan Lewis & Bockius. Ruskin adds that this has important implications for self-audits as well. “If the provider determines there’s evidence that the service was furnished, even if not in accordance with CMS’s subregulatory guidance, then perhaps the entity gathers that evidence in a file as an indication of its good-faith belief that it does not have any overpayment liability,” he said in spring 2009. However, make sure there’s no regulation on point that requires specific items in the medical record.

If the entity disagrees with the regulation, it can always file a claim under protest, knowing that it will be denied but preserving its appeal rights, Ruskin says. Of course, that’s not the ideal position to be in, he says. “You’d rather just have your money and not have to fight for it,” he notes. Where documentation problems are found, Ruskin says that, in his experience, additional training of staff and periodic auditing have had a salutary effect, meaning that often the same problem doesn’t come up twice.
San Francisco attorney Judy Waltz agrees that, when providers lack the types of documentation that CMS or its contractors usually see for a particular type of item or service, they should look for alternative documentation to establish an equivalency. “For example, I have argued that lab tests lacking a physician order to establish the reason for the test can demonstrate medical necessity by looking at how the physicians altered treatment in response to a lab test,” she said in spring 2009. “Or allegations of inadequate supervision of staff can sometimes be refuted by physician calendar entries. It’s certainly more difficult than having great documentation. If an item is specifically required as a condition of payment, then it needs to be there. But providers need to be creative in figuring out what they have to work with when challenged with deficiencies.”

Part of the problem is the government has long contended that “a documentation defect relieves the government from paying for services that were actually rendered, even in instances where quality and medical necessity are not at issue,” says New York City attorney Mark Thomas, who represents the Healthcare Assn. of New York. But he sees little basis for this, other than what he calls a rigid application of general rules and payment certifications that condition payment on 100% compliance with all applicable regulations. “This perspective, however, conveniently ignores the obligation of any payer, including the government, to pay for services it covers and does not question,” Thomas said in spring 2009. “It would be immensely productive to have a candid exchange of views on the propriety and basic fairness of the all-or-nothing system we now have.”

Hospitals Should Utilize Their In-House Data to Fight Auditors’ Fire With Fire

Hospitals have in-house data they can use in ways that will help level the playing field with Medicare auditors, starting with outpatient code edits (OCEs). As recovery audit contractors (RACs) and other program-integrity contractors bear down, it’s becoming increasingly important for hospitals to analyze claims before and after they’re prepared for submission to determine what edits their claims are hitting repeatedly and what systemic changes would improve claims accuracy.

“Hospitals can do their own data mining and analysis at a very low cost, though it may be labor-intensive,” says Cheryl Rice, vice president and chief corporate responsibility officer at Catholic Healthcare Partners, a Cincinnati-based nonprofit health system with 32 hospitals and many other entities. “Your own claims processing system has the edits that CMS uses to do data mining of potential problems. You can start by targeting a few outpatient code edits around the core RAC targets and get a feel for how at risk you are,” she said in August 2009.

CMS developed outpatient code edits as a program-integrity tool. Medicare administrative contractors (MACs) and fiscal intermediaries apply them when processing claims, and program-integrity contractors, such as RACs, use them during audits. Outpatient code edits identify claims that are problematic on their face. For example, OCE 1 detects invalid diagnosis codes, and OCE 3 detects a conflict between diagnosis and gender. Outpatient code editors also get very specific. For example, OCE 29 flags partial hospitalization (a psychiatric treatment) for a non-mental health diagnosis. OCE 49 identifies a service performed on the same date as an inpatient procedure. OCE 43 detects when Medicare was billed for a blood transfusion without corresponding blood products.
If the outpatient code edit is triggered, Medicare can deny the entire claim, deny the line item or suspend the claim and ask for more information before making its payment decision. But CMS and its contractors do more with outpatient code edits than reject claims that make no sense. “They use the information from code edits for data mining,” Rice says. With the vast amount of data in the Medicare claims system data warehouse, Medicare contractors of all stripes can use outpatient code edits to search for patterns and trends of aberrant billing. That’s why the first round of RAC audit targets were almost a no-brainer except for what they foreshadow in future audits. For example, the first RAC audits focus mostly on claims for services that have a one-unit limit per patient per date of service. An outpatient code edit easily spots when that has been exceeded.

“This is an advantage the government has over us — a way to look for patterns and trends and compare ourselves to others,” Rice says. “We have to think of ways to do self-evaluation and peel back the layers of the onion.”

### Working Outpatient Code Edits to Improve Compliance

Cheryl Rice, vice president and chief corporate responsibility officer at Catholic Health Partners in Ohio, says hospitals have a wealth of internal resources at their disposal for data mining and analysis, which is key to reducing payment errors. The outpatient code edits below are a good place to start.

**OCE Edits to Focus On:**

- Data mining automated review targets:
  - 0001, 0002, 0003, 0006, 0007, 0008, 0022, 0023, 0025, 0026, 0041

- Service billing issues
  - Inpatient only reported on outpatient claims 0008, 0045, 0049
  - Missing services or items associated with a certain procedure or service = 0038, 0042, 0043, 0044, 0071, 0077, 0078
  - Wrong or missing Revenue Centers for charge items requiring special coding = 0048, 0065, 0079

- Frequency or units issue = 0015, 0016

- Wrong site of service or type of provider of service = 0014, 0028, 0029, 0055, 0061, 0062, 0063, 0064, 0072, 0080, 0081

- Statutorily non-covered/non-covered services or outside of approval = 0009, 0012, 0013, 0047, 0067, 0068, 0069, 0083

- Duplicated services = 0016, 0037, 0051, 0054,

- Partial hospitalization = 0029, 0030, 0031, 0032, 0033, 0034, 0035, 0036, 0046, 0063, 0064, 0080, 0081

- 0039 & 0040 — RACs are focusing on these

- 0071— high dollar device not coded, not charged or no procedure issued

- 27 — Only incidental services reported
  - Missing charges for main procedures
  - Charges on wrong claim
  - Unbundled charges that should be part of larger service
Six Steps Are Recommended

What does that mean? Capitalizing on your own internal claims processing systems and internal data systems — particularly outpatient code edits — to identify the volume and cause of errors and find ways to reduce them. Here are six steps that Rice recommends for that process:

1. Determine which outpatient code edits your hospital is routinely hitting.
2. Compare a set of “pre-scrubbed” claims to “post-scrubbed” claims. Pre-scrubbed claims are unprocessed claims that contain only clinical information and charges; post-scrubbed claims have gone through the computer system’s edits and been worked by billers so the claims will be paid.
3. Examine why the edits were triggered for this set of claims and how they were resolved. Was a chargemaster correction required? Did a coder require training? Were clinicians misconstruing some charges? Were there process problems or technical problems, such as with a table file? Or was it a hiccup in the software?
4. Don’t let billers write off charges as a “solution” to outpatient code edits. High-quality billers don’t do this, Rice says. But billers unwilling to trouble-shoot until they solve the mystery of why the claim is kicking out may take this approach. Aside from sacrificing the hospital’s money, writing off charges doesn’t solve problems because the claim won’t accurately represent the services provided, and other edits will be triggered. For example, recently a biller was faced with a confusing situation: a claim for a blood transfusion was rejected because it lacked information on the blood products. The biller decided to try to bypass the outpatient code edits by simply dropping the transfusion from the claim. That left only lab work for typing and crossing the blood on the claim. “There was a transfusion with no blood products, so the biller figured there couldn’t have been a transfusion and removed it from the claim,” Rice says. In a quality check, another biller noticed that the type and cross charge was on the claim but no blood or transfusion charges, which typically occur together. The second biller asked questions of the clinical department and received the correct information. “It’s important to work the claim and ask the questions. It requires you to have billers with good critical thinking and investigative skills,” she notes.
5. Determine whether CMS found additional issues or errors. “Get feedback by looking at remittance advice comments and reason codes and remark codes,” Rice says.
6. Tap into your denials management team for information on specific errors or issues and to explore compliance trends. “You need to have a more detailed tracking of reasons and types of services for denials,” she says.

Catholic Healthcare Partners uses another approach to compare claims before and after they have been worked by billers. Using a snapshot tool in its 3M software, a set of pre-scrubbed claims is compared to its post-scrubbed version. This may reveal that the digits of a CPT code were transposed or the ICD-9 diagnosis code is entered for the date of charges, not the date the services were provided. (ICD codes are updated every October.) Coders might need more training, policies and procedures might need adjusting, the chargemaster might need updating, etc.

The goal is to identify the interventions necessary to transform a raw claim into a billable claim so they can become embedded in the hospital’s routines, not just ad hoc measures designed to prevent a claims rejection. It’s far more efficient and cost-effective to make permanent changes.

“Your goal should never be ‘I will correct this on the back end.’ Your goal should be ‘I will fix this on the front end.’ Otherwise it will always be a shotgun approach.” Special software isn’t essential, Rice says, so hospitals can do this manually as well.
Coding from Medical Records vs. Chargemaster

One challenge that health systems will face as they use data to improve the quality of claims is sorting out the best way to derive codes in different categories. Should a particular set of codes be hard-wired into the chargemaster or assigned by coders from medical records? As a general rule, services and procedures (e.g., labwork, radiology) where there is little or no variation should be put into the chargemaster, Rice says. However, “when you have procedures done many different ways with different techniques and different CPT codes reflecting those techniques, that’s when you want coders. [They] read doctors’ notes,” thinking through and making often complex decisions about which codes to assign, she says. “Most surgical codes are not hard-wired into the chargemaster.” As surgery gets more sophisticated and involves more codes and modifiers, coders may make more of the decisions, and more compliance oversight may be necessary.

Rice says hospitals don’t need a consultant to produce edit data, but they may need consultants to help develop automated tools to trend edit data. “You have the data to tell you if you have potential issues. You already have a claims processing system that has edits built into it. You need to figure out what edits you’re hitting and share that information with a multidisciplinary team. Sit down and figure out with them how to fix [the problems] identified. Don’t just write things off.” This approach has worked at Catholic Healthcare Partners to improve overall outpatient claims accuracy.

Adopting the Same Admission Criteria as RACs Is Expensive and Not Necessary

In their search for ways to shield themselves from the financial dangers of program-integrity reviews, hospital compliance officers are wondering whether to adopt the same inpatient admission screening criteria that are used by their recovery audit contractors (RACs). If they use InterQual and the RAC uses Milliman, maybe they should switch, and vice versa, but that can be an expensive move.

But CMS and an industry medical-necessity expert say that’s unnecessary. This revelation will come as a big relief to hospitals that have been obsessing over this, especially in states like Iowa where the Medicare administrative contractor (MAC) uses InterQual, the quality improvement organization (QIO) uses Milliman, and the RAC plans to apply both sets of criteria.

A hospital’s perception that it should use the same inpatient admission screening criteria as its RAC to review inpatient admissions has intensified as the national RAC program gets under way, says Joe Zebrowitz, M.D., executive vice president of Executive Health Resources, a Philadelphia firm that works with hospitals on medical-necessity compliance. “People are in a panic about this,” he said in summer 2009. They think they’re safer if they use the same admission screening criteria as their RAC, “but that’s generally not the case.”

The anxiety on this issue is understandable, since during the RAC demonstration CMS recouped hundreds of millions of dollars from hospitals in five states for alleged medically unnecessary inpatient admissions and inpatient services.

The InterQual versus Milliman debate may be beside-the-point. Marie Casey, deputy director of the CMS Division of Recovery Audit Operations, told AIS in summer 2009 that “the RAC statement of work does not mandate that a specific screening criteria be used in the review of claims. The RACs do have access to both Interqual and Milliman; however, a RAC would not deny a
claim strictly based on the fact that the screening criteria indicates that the admission should not have occurred.” Casey notes that InterQual and Milliman are only one tool in the RAC tool box. “These guidelines are not CMS-approved policy,” she notes.

Zebrowitz agrees with CMS’s position on the selection of screening criteria, and provides additional advice for hospitals in the process of choosing an inpatient screening tool or changing to a tool that matches its auditors. “Just because your RAC uses a particular screening tool doesn’t mean you have to switch to that tool,” he says, because InterQual and Milliman are only one method for determining medical necessity. However, “if a hospital is intent upon using the same screening criteria as a government contractor, it probably makes most sense to adopt one of the tools used by its MAC.” Zebrowitz notes that MACs conduct prepayment and post-payment audits and rule on the first level of appeals in RAC overpayment determinations, while RACs do only post-payment audits.

Ultimately, though, whichever admission screening criteria hospitals embrace should have no bearing on a RAC or MAC denial. What matters is that hospitals use an evidence-based screening tool that’s accepted by the medical staff “as a part of a compliant admission review process that includes secondary physician review as appropriate,” Zebrowitz says. “If they have a compliant admission review process incorporated into the hospital utilization review plan and UR committee, and, if that compliant process results in the determination of inpatient admission status, then it is reasonable to assume that the provider could not have been expected to have known that the services were excluded from coverage at the time they were delivered.”

**Hospitals Protected Under Liability Provision**

Given this, Zebrowitz states that the provider would meet the regulatory requirements of reasonable and necessary care and would be afforded the protections of the limitation on liability provision of Sec. 1879 of the Social Security Act (42 CFR 411.406(c) and (e)). In other words, hospitals could not have known their services were medically unnecessary if they qualify for this provision.

According to Zebrowitz, a compliant admission review process that provides limitation-on-liability protections should include:

1. The use of evidence-based inpatient screening criteria for the purpose of first-level admission review by a non-physician, which are accepted by the medical staff and incorporated into the hospital UR plan. While hospitals may use the screening criteria specific to a particular MAC, RAC or QIO, no requirement exists for providers, and this should not be the sole basis for intermediary denial. Zebrowitz says RACs would be hard-pressed to argue that a hospital should have known a claim lacked merit when the hospital, in good faith, used an evidence-based and industry accepted admission screening criteria tool as part of its process. If the RAC denies a claim based solely on the application of a different screening criteria tool but the hospital has a compliant admission review process, the hospital has an excellent basis for appeal. Zebrowitz further suggests that hospitals ensure they appropriately document their admission review process and create an auditable document trail to provide evidence of a compliant admission review process during the Medicare administrative appeal process.

2. The use of appropriate second-level physician review for the evaluation of cases that don’t meet inpatient screening criteria requirements. CMS states in Ruling 95-1 that medical-necessity determinations should rest heavily on evidence-based medicine. “Medicare contractors, in determining what acceptable standards of practice exist within the local medical community,
rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts,” the ruling says. This is CMS’s way of saying that when physicians conduct the more subjective second-level reviews of medical-necessity decisions that won’t fit squarely in InterQual or Milliman, they should turn to an evidence-based, literature-based medical expert opinion. “95-1 isn’t easy to adhere to — it’s not just one doctor’s opinion of what a standard of care is. However, a good second-level physician review process that refers to appropriate clinical evidence and data will ensure you are able to clear that hurdle,” Zebrowitz says.

There is another reason why hospitals using different admission screening criteria than their RACs do shouldn’t switch. “Getting new criteria is a big commitment” — it involves additional organizational costs and requires investment in extensive training of case managers, Zebrowitz says. That’s why adopting the MAC’s method might be preferable. “MACs as a program are likely more stable,” Zebrowitz notes. RACs may not last forever, but MACs will always be here to pay Medicare claims. MACs have already proven their appetite for medical-necessity reviews. For example, he says, MAC Trailblazer Health Enterprises, LLC recently did an audit of 250 elective cardiac stent procedures and said it found a greater than 98% error rate. “Hospitals rarely do admission reviews of stents,” he says. “They are a perfect target, and the Trailblazer results suggest how aggressive the MACs can be.”

### More Payers and Auditors Are Accepting Documentation From Non-Physicians

Medicare and other payers were in March 2010 accepting more nonphysician documentation, which should improve coding and help support hospitals in their appeals of unwarranted claims denials by program integrity contractors.

So far, coding based on documentation from non-providers is limited to certain areas — including body mass index, pressure ulcer staging and services provided by non-physicians — but it’s possible the door will open wider, especially when ICD-10 diagnosis codes take effect in three years.

“What’s new is that payers and auditors are really starting to accept documentation from other practitioners,” says Ann Russo, vice president and director of DRG services at Health/ROI in Metuchen, NJ. That means hospitals and physician clinics should look for documentation by ancillary providers when trying to support their position that a claim was billed accurately, says Robert Jacobs, president of Health/ROI.

According to Coding Clinic, the coding newsletter published by the American Hospital Assn., coders must rely on documentation from “providers,” says Nelly Leon-Chisen, executive editor of Coding Clinic and AHA’s director of coding and classification. The definition of “provider” is “the individual legally accountable for establishing a diagnosis,” says Coding Clinic, which was created by four “cooperating parties” — CMS, the American Hospital Assn., the American Health Information Management Assn. and the National Center for Health Statistics. “Officially, you have to code from provider documentation and ‘provider’ is defined in some very strict terms as far as ICD guidelines are concerned,” Leon-Chisen tells AIS.
Clinicians Must Be ‘Legally Accountable’

The most common definition of a “provider” is a physician. But Coding Clinic doesn’t rule out all coding from documentation by clinicians who are not physicians. “It would be appropriate to use the health record documentation of other providers, such as nurse practitioners and physician assistants, as the basis for code assignment to report new diagnoses, if they are considered legally accountable for establishing a diagnosis within the regulations governing the provider and the facility.”

Coding Clinic and the four cooperating parties have also carved out some very specific non-physician documentation niches, which should offer relief for hospitals that are struggling to gather documentation for Medicare auditors to support their claims, according to Russo and Jacobs.

The staging of pressure ulcers is one area where coding and documentation guidelines were relaxed by the four cooperating parties. The pressure-ulcer diagnosis — the fact that it exists — must come from a provider, says Leon-Chisen. But when it comes to reporting the stage of an ulcer (I, II, III, IV, unstageable), coders are permitted to use notes from other types of clinicians (e.g., wound care nurses, physical therapists), she says. If the nursing notes describe the staging of the ulcer but the physician never mentions it, coders have to “go back and ask [the physicians] to document the presence of the ulcer,” she says.

Body mass index (BMI) is a second area where coders can use documentation from clinicians who are not defined as “providers,” according to the four cooperating parties. Leon-Chisen explains that providers document the malnutrition or obesity diagnosis, but registered dieticians get into the weeds with documentation of BMI. “The fact the patient is obese must be documented by the patient’s physician. The physician has to document the underlying diagnosis that basically makes it clear why the BMI is so important,” Leon-Chisen says. She notes that dieticians often document BMI in a nutritional consult, but physicians don’t necessarily pick it up.

“For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider… since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietician often documents the BMI and nurses often document the pressure ulcer stages),” according to the ICD-9-CM Official Guidelines for Coding and Reporting (pages 12-13). “However, the associated diagnosis (such as malnutrition, obesity, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.”

The guidelines emphasize that codes for BMI and pressure ulcer staging can only be reported as secondary diagnoses. “As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis,” the guidelines say.

More Leeway for Respiratory Therapy

Although it’s not in the cooperating parties’ guidelines, Coding Clinic states that coders can use some of the details provided by non-physician providers, especially when they are typically not documented by physicians. And “anything in Coding Clinic is approved by the four cooperating parties,” Leon-Chisen says.
Russo notes that respiratory flow sheets, which are filled out by respiratory therapists, “have become vital parts of documentation.” Coders can use respiratory flow sheets to report the fact that mechanical ventilation was provided and for how long, but not for diagnoses reported by respiratory therapists unless they have been documented by providers.

Recovery audit contractors (RACs) may soon be testing these waters as CMS has recently approved several DRG validation audit issues for RAC review, which may hinge on the establishment of a minimum of 96 hours of mechanical ventilation, Russo notes. Often, this can be established only through detailed documentation in the respiratory therapy notes.

These are the areas explicitly carved out for coding in terms of non-provider documentation, but Russo and Jacobs think it’s possible that the future will bring more flexibility — especially with the 2013 implementation of ICD-10 diagnosis codes. There are far more ICD-10 codes than ICD-9 codes and the level of complexity and specificity may require more input from other kinds of clinicians, they say.

“It seems like physicians are finally getting pushback to say ‘my documentation is vague in certain details, but a multidisciplinary team of people is taking care of the patient. Let us use other disciplines to provide and document comprehensive assessments and care,’” says Ellen Scott, director of Health/ROI’s appeals management service.

It’s unclear how the cooperating parties and Coding Clinic will react. “There have been requests for a while to change the guidelines, but we have been reluctant because you don’t want someone who’s not a physician to make diagnoses,” Leon-Chisen says. “It’s different for diagnoses versus procedures. A diagnosis is more a judgment and you could have conflicting judgments” (e.g., what one physician calls respiratory insufficiency, another physician calls failure, and these interpretations have different codes). “One person can consider the patient sicker than the other,” she says. In contrast, procedures are more a direct reporting of what a clinician performed.

Compliance Workload, Responsibility Grow With Heightened Enforcement

The growth in government audits and enforcement is changing the nature of the compliance program at MedStar Health, which includes nine hospitals and other entities in Maryland and Washington, D.C. In addition to expanding the volume and types of compliance audits performed by the compliance team at the nonprofit health system, the highly charged environment has raised the profile of compliance and intensified demand for its expertise on everything from audits to writing policies.

With the growth in compliance workloads, the compliance department has developed a system for tracking and analyzing requests for its assistance.

“Increasing regulatory enforcement has affected how the compliance program operates,” said attorney Susan Walberg, MedStar’s corporate compliance officer, in March 2010. “Back in the day, you’d look at the OIG Work Plan, do a risk assessment and then do your own work plan and go forward. Now we look at the OIG Work Plan as just one thing.”

Compliance Is Now on ‘Speed Dial’

There is much more activity to anticipate and/or respond to, including requests from the Comprehensive Error Rate Testing (CERT) contractor; reviews by recovery audit contractors
(RACs), zone program integrity contractors (ZPICs) and Medicaid integrity contractors (MICs); and medical reviews by Medicare administrative contractors (MACs). “We are doing a lot more data analysis, a lot more tracking and trending, and have broadened the scope as we try to capture what is going on in real time,” she says.

In addition to generating significantly more responsibility for the compliance program, RACs, MICs and other auditors and investigators are a publicity juggernaut that put the compliance program on MedStar’s internal map. “There is heightened awareness across the organization,” Walberg says. MedStar executives will read an article about a Stark-related False Claims Act settlement, and wonder whether the compliance office should conduct a review at their hospitals for the same kind of potential liability. “People knew we existed but we weren’t on speed dial,” she says about the compliance program. That’s all changed. “We are spread much thinner because we are doing so much more.”

For example, MedStar’s compliance program used to do mostly planned, routine audits and coding reviews, with an emphasis on providers’ documentation and coding, Walberg says. Now

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<thead>
<tr>
<th>Form for Tracking Internal Compliance Requests</th>
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<tr>
<td>MedStar Health’s compliance department developed this form to document the process of serving nine hospitals and other entities.</td>
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**Office of Corporate Business Integrity (OCBI) Service Request Checklist**

**Intake**

1. Document the information received during intake into the proper form and/or database.
2. Document the request received date.
3. Discuss the timeline in which the requestor would like to receive their deliverables. THIS MUST BE ENTERED ON THE FORM.
4. Be sure the timeline given is feasible or realistic.
5. Obtain the service request number from the Clinical Project Data Manager upon receipt prior to the OCBI weekly staff meeting.
6. Get a detailed description of the work that is being requested.
7. If it is an “ASAP” request, discuss with an OCBI Director or Corporate Compliance Officer immediately.

**Assessing and Assigning Request**

8. Fill out the service request form in its entirety and present it during the OCBI weekly staff meeting.
9. Get input from the group in terms of who has the time and skill set to complete this request.
10. If this is a significant issue that may require a substantial amount of time, please discuss with an OCBI Director.
11. If you are the primary person assigned, make contact with the requestor to discuss the timeframe, deliverables, and process to be sure there is a meeting of the minds.
12. Track all time spent on the service request and follow up with secondary for their time spent if applicable.

**Reference/Resources**

13. Establish the type of service request received.
14. Identify the resources needed:
   - Does this request require a review of a policy, standard, and/or law?
   - If a policy, is it an internal or external policy?
   - Is the issue related to state and/or federal regulations? (e.g., Medicaid or Medicare)
   - What category does the issue fall under? (e.g., hospitals, billing and coding, DME, etc.)
   - If it is a hospital issue, did you look to the Joint Commission Standards?
   - Is it area-specific such as dermatology, radiology, etc.? Please check their professional association websites.

**Completion**

15. Fill out the service request form in its entirety.
16. Remember to keep track of your time spent on the request.
17. Accurately document your deliverables.
18. Meet all the requirements of the requestor? (e.g., request fulfillment, deliverables, designated timeframe, etc.)
19. Remember to notify the Clinical Data Project Manager upon completion of the request.

SOURCE: © Copyright MedStar Health
the compliance team engages far more often in unplanned reviews in response to a MAC audit or a CERT request, or a concern raised by a MedStar hospital or other business unit. For example, if the MAC audits one MedStar hospital’s use of a particular code, that “gives us a lot of impetus internally to do our own review” of the other MedStar hospitals’ use of that code, she says. Training and education are part of the package to prevent problems at the other hospitals. “We tell them where to go look, give them parameters and a checklist and if there is a problem, we can try to get ahead of it,” Walberg says.

The compliance department has also been put in charge of managing RAC response for the system. The department is overseen by a RAC steering committee comprised of senior leaders (e.g., CFO, chief medical officer). However, each MedStar hospital has its own RAC team to pull and review medical records, with different people developing and managing different pieces (e.g., the appeals process). “Our role is to be overseer and coordinator at the corporate level,” Walberg says. “It’s more a herding process.”

All of these reviews “trigger a ton of work” compared to the standard audits that were performed before the federal government flooded hospitals with auditors.

And that’s just the compliance department’s response to outside demands from the audit and enforcement machinery. Compliance also receives far more “service requests” from MedStar entities and corporate leadership, Walberg says. MedStar staff may request audits, new policies or advice, among other things.

“People in other functional areas, such as finance, quality and risk management, now understand our role better and see more opportunities for collaboration,” Walberg says. “They are much

<table>
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<th>Service Request Summary Report</th>
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<tbody>
<tr>
<td>This spreadsheet keeps track of the number, type and status of tasks performed by the compliance department for each entity in the MedStar family.</td>
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| Service Request Status: Totals | 18 | 6 | 0 | 24 | 0 | 0 | 5 | 4 | 2 | 59 |

| Number of Hours | 214.5 | 37 | 0 | 259.5 | 0 | 0 | 12 | 59 | 7 | 589 |
more engaged and interactive with us and come to us much more frequently. As things heat up, compliance has become more visible at the corporate level and out in the field. It’s a very interesting shift,” she adds.

This is a big change from the days when compliance was generally perceived as “the ugly stepchild,” Walberg says. “We are getting involved in corporate-level projects that historically we were not involved in, like implementing an enhanced conflict-of-interest policy.”

In fact, the service requests are so abundant that the compliance department spent more than 800 hours fulfilling them in 2009, Walberg says. Requests are all over the map. They range from “audit this issue because we may have a problem” to “help us write a policy” to “we need a template for physicians to bill a certain service” to “come investigate this potential wrongdoing.” Walberg says it can be anything within the scope of compliance, but is beyond the scheduled internal compliance work plan topics. The compliance team has also been called to consult in areas beyond its expertise (e.g., durable medical equipment and pharmacy).

To document the service requests from intake through completion, Walberg and her staff created a service request checklist, including a spreadsheet to track the number of projects completed monthly per MedStar entity.

Service requests are a good way to show we are not just doing the reviews and projects on our work plan,” she says. The tracking form and spreadsheet are valuable to document everything that’s being accomplished because sometimes compliance will have to delay a project or find an alternate method for doing it (e.g., telling the department that compliance lacks the time to craft the policy, but is happy to review it). “Part of the service-request process is designed to show we have limits, and evaluate whether we can do it and negotiate with the internal client,” Walberg says. “Maybe we’ll say it won’t be before next month.”

The service request checklist also helps compliance verify that areas outside the department’s normal scope will still get addressed appropriately, Walberg says. For example, “our department isn’t typically involved in Joint Commission or licensure problems or conditions of participation,” but there might be overlap with more traditional compliance areas (e.g., billing). “Everyone comes to the table with their own lens, so we try to come up with possibly related things you might miss and drill it down,” she notes. If the issue implicates something outside the scope of the compliance team’s expertise, she coordinates with risk management or the legal department, for example.

“When we go through the checklist, we work with the people who have the greatest expertise rather than write a policy that addresses regulatory requirements but does not meet Joint Commission standards, for example. We want to make sure any work product coming out of our office will meet the customers’ needs and all the applicable standards,” Walberg says.

With the compliance focus increasing at MedStar entities and at the corporate level, Walberg expects it to attract more resources. That will be increasingly essential as compliance increases its interaction and collaboration with other departments, such as quality, risk management, legal and internal audit. “The movement is for compliance to operate cross-functionally,” Walberg says. “It has to have a broad scope.” ♦
Confusion Over Gastroenterology Coding Surfaces During Audits

Gastroenterology procedures are an important source of hospital revenue and therefore an inevitable target of recovery audit contractors (RACs) and other program-integrity auditors. Because they have already made the RAC hit list in different forms — DRG validations (e.g., major small and large bowel procedures) and coding for more than one unit (e.g., bronchoscopies) — gastroenterology is ripe for self-auditing.

In her audits of hospital outpatient gastroenterology procedures, Trina Jayne, a clinical data analyst with Pyramid Healthcare Solutions, has found both overcoding and undercoding. In particular, coders tended to make mistakes when coding esophagogastroduodenoscopy (EGD), a procedure to identify problems with the upper digestive tract. They may downcode to esophagoscopy, a procedure for evaluating and treating esophageal disorders.

“We had to do a lot of education on esophagoscopies versus EGD,” said Jayne, a certified coder, in January 2010. EGD (which has a CPT root code of 43235) pays significantly more than esophagoscopies (which has a CPT root code of 43200).

What causes the EGD errors? Jayne explains that sometimes coders are confused about EGD coding criteria and mistakenly think physicians haven’t performed the work necessary to warrant coding EGD. They may downcode to esophagoscopy, which only involves advancing a scope as far as the esophagus. An EGD requires the physician to enter the esophagus, stomach and either the duodenum or jejunum (whichever is appropriate). It doesn’t mean a procedure has to be performed in the duodenum or jejunum, but that’s what some coders think, Jayne says. When physicians stop at the esophagus to do a procedure, coders may erroneously believe they can’t code EGD with a procedure. But if the physicians advance all the way to the duodenum or jejunum — even if it’s just to look around — and documentation supports it, the coder can code for EGD with a procedure and the hospital can collect the reimbursement it’s entitled to.

Here are three other errors she finds in gastroenterology procedures:

(1) Fiducial marker placement: Hospitals miss out on reimbursement if coders are unaware that fiducial marker placement now has its own HCPCS code (C9728). Markers may be used to make features of an image more visible when they are invisible or difficult to distinguish. A fiducial marker is a type of interstitial marker that can be used before radiation as a point of reference. Until recently, it didn’t have its own code. As a result, Jayne says, “this is getting missed.”

(2) Biopsies: Coders confuse the three different types of colonoscopy biopsies, Jayne says. The three types are cold forceps biopsy (portions of the biopsy), which is CPT code 45380; snare or cold forceps biopsy (entire biopsy), which is CPT code 45385; and hot or cautery biopsy, which is CPT code 45384. “Coders get mixed up because sometimes physicians aren’t really clear about what they are saying” in the documentation, she says. “If you read the medical records really quickly, you might miss something.” One solution: coders can examine the notes in pathology reports to determine the nature of the biopsy.

(3) Fine needle aspiration: That often gets reported when it wasn’t documented properly, or it’s confused with a biopsy.
RAC Reviewers Hit Hard on Debridement; Five Elements Must Be Documented

The tension between two competing needs — to have all documentation before coding charts and to keep reimbursement rolling in — creates compliance vulnerabilities for hospitals, particularly in high-risk areas like debridements.

Which one will prevail in the competition will become apparent, as debridement-related MS-DRGs are facing complex medical review by two recovery audit contractors, and the other two RACs may join the party as well.

“Medical records departments are constantly hammered to reduce the ‘DNFB,’” an acronym for “discharged not final billed,” said Donna Pizzulli, executive vice president for Cybergistics Records Management in Neptune, N.J., in February 2010. The term refers to claims that have not been submitted yet because coders lack the documentation necessary to code charts, even though the patient has left the hospital.

As the DNFB rises and reimbursement is not received in a timely manner, the CFO becomes unhappy. “It is big-time pressure. Coders are coding incomplete charts. Everybody does it, whether it’s electronic or paper [charts],” she says. Against that backdrop, the higher-paying version of debridement — excisional debridement — is easy prey for incomplete documentation and the overpayments that stem from it.

To code for excisional debridement, there must be five documentation elements in the operative report or description of the procedure, Pizzulli says. If any are missing, coders or clinical documentation improvement specialists should query physicians for elaboration or clarification of the patient’s treatment. But that may increase the DNFB. Feeling the heat to get charts coded and out the door, coders either downcode to non-excisional debridement, which may deprive the hospital of deserved reimbursement, or assign the excisional debridement code without all five elements. “Ninety percent [of errors] are documentation issues,” Pizzulli contends. Connolly Consulting, the RAC for Region C (which includes 15 states in the south and southwest), is now conducting DRG validation for 14 debridement MS-DRGs, including skin graft and/or debridement for skin ulcer or cellulitis with complications/comorbidities (MS-DRG 574); skin graft and/or debridement for skin ulcer or cellulitis with major CC (573); and skin graft and/or debridement for skin ulcer or cellulitis without CC/MCC (575). CGI, the RAC for Region B (which includes seven midwestern states), is validating nine excisional debridement MS-DRGs, including wound debridements for injuries without CC/MCC (MS-DRG 903), wound debridements for injuries with MCC (901) and wound debridelements for injuries with CC (902). DRG validation is the process of evaluating whether documentation supports the diagnosis, procedure and discharge disposition and determining if codes have been grouped to the correct DRG. It does not address the necessity of inpatient admissions.

More Options Exist Under MS-DRGs

When RACs reviewed and recouped millions of dollars in debridement overpayments during the three-year RAC demonstration, which ended in March 2008, they targeted only a handful of DRGs. Since then, CMS implemented severity-based DRGs, expanding the number of DRGs from 538 to 745 and breaking them down to a much greater extent by secondary diagnoses. “The list has gotten larger because of the MS-DRG changes that burst the twins into triplets in addition to adding totally new DRGs,” Pizzulli says.
Physicians perform debridement to remove necrotic, infected tissue from wounds and burns and promote healing and new tissue growth. There are two categories of debridement:

(1) Non-excisional (ICD-9-CM code 86.28) is not a surgical procedure. It involves the non-operative brushing, scrubbing, whirlpool or washing of devitalized tissue, necrosis or slough. However, minor snipping and maggot therapy are included in the description, Pizzulli says.

(2) Excisional debridement (ICD-9-CM code 86.22) requires the surgical removal or cutting away of necrotic or devitalized tissue. This procedure may be performed in the operating room, emergency department or at the patient’s bedside, she says. “To be in compliance, it is essential that physician documentation support the use of 86.22,” Pizzulli says. RACs will recoup money for excisional debridement unless the magic word “excisional” is in the medical record, she says.

To support use of the 86.22 code, the following five elements must be documented:

- The technique used (e.g., scrubbing, brushing, washing, trimming, or excisional);
- The instruments used (e.g., scissors, scalpel, curette, brushes, pulse lavage etc.);
- The nature of the tissue removed (slough, necrosis, devitalized tissue, non-viable tissue, etc.);
- The appearance and size of the wound (e.g. fresh bleeding tissue, viable tissue, etc.)
- The depth of the debridement (e.g., skin, fascia, subcutaneous tissue, soft tissue, muscle, bone)

This procedure was: ___ Excisional Debridement   _____Non-excisional debridement

Please provide specific information on the areas that have not been checked and document this information in the patient’s medical record or via this form below, which will become a permanent part of the patient’s medical record.

Without this documentation, we must code the procedure as non-excisional and you should not bill for an excisional debridement procedure.

The justification for payment to the medical facility and to the physician is the medical record. The provider’s signature block on the CMS 1500, used for submitting claims for services, states: “I certify that services shown on this form were medically indicated and necessary for the health of this patient.” If the codes submitted do not match the services documented in the patient’s medical record, reimbursement can be affected under the guidelines of the federal False Claims Act. CMS seeks complete, legible, understandable and concise documentation that will support the medical necessity of treatments being provided.
The appearance and size of the wound (e.g., fresh bleeding tissue, viable tissue, etc.); and

The depth of the debridement (e.g., skin, fascia, subcutaneous tissue, soft tissue, muscle, bone).

Physicians may drop the ball on one or more of these elements in terms of documentation. For example, the operative report may never mention the word excisional or the physician may state that “large amounts of necrotic fascia over the sacrum was debrided” without saying how deep he or she went, she says.

When physicians don’t include all this information, Pizzulli recommends “coding it to the best-case scenario in terms of accuracy and financial ramifications. But put a bill-hold on it. Then query the doctor and have the doctor re-review the medical records and give you the appropriate documentation.” And warn coders not to take shortcuts. “You don’t get a second bite at the apple when the RAC comes,” she notes. “But you do when you are coding in real time because you can go back and get the documentation that you need.”

The good news is that reducing debridement errors doesn’t require you to move mountains, which is the case in other areas. “Debridements are cut and dried,” Pizzulli says. “There are five things to document. You’ve got to get those buckets complete — the instrument used, how deep you went, etc. — and then you’re golden.” And decision making in this area is objective; either a debridement is excisional or it’s not. Physicians can argue endlessly about the definition of “sepsis” or whether a diagnosis was present on admission, for example, but excisional debridement is not very subjective, she says.

Pizzulli says hospitals should identify the physicians who perform excisional debridement — they are surgeons and usually a limited number of them — and do a 15-minute targeted education session on debridement documentation. Or prepare a documentation guideline and send it to the doctors performing debridements.

Finally, get case management or clinical documentation improvement specialists involved on the front end. Have them work with physicians to improve their documentation on a real-time basis before patients are discharged and the records are sent to the health information management department.

Hospitals Face Medical-Necessity Denials Despite Getting Green Light From InterQual

Auditors for some Medicare Advantage plans in February 2010 were starting to deny inpatient claims even though the cases meet InterQual admission screening criteria. The same situation could unfold with recovery audit contractors (RACs) because CMS has said that meeting InterQual criteria doesn’t guarantee the claim will be deemed medically necessary in the eyes of Medicare.

An InterQual or Milliman medical-necessity imprimatur is seen as a reliable predictor of Medicare claims approval, but if the sands shift, hospitals will have to redouble efforts to make sure physician documentation tells the story of severity of illness and intensity of services, experts say. It’s not enough to state the existence of serious complications, for example; physicians must explain how the complications endanger the patient unless he or she is admitted to the hospital.
This turn of events with the auditors for Medicare Advantage plans is a twist on the problems experienced during the recovery audit contractor (RAC) demonstration, when hospitals appealed claims that were denied because they did not satisfy InterQual or Milliman. When that happens, hospitals can argue that admitting physicians had credible reasons for overriding screening criteria. This time around, “RAC-like” contractors hired by some Medicare Advantage plans (e.g., Humana) are doing the reverse: declaring inpatient admissions medically unnecessary despite the InterQual green light.

This development does not sit well with a compliance official at one hospital that just got its first denial from the Medicare Advantage plan’s RAC-like auditor, which doubles as an actual RAC. “They don’t care if it passed InterQual,” says the compliance official, who declined to be identified. The denial was based on one person’s opinion: the medical director for the Medicare Advantage RAC-like auditor. “The physician reviewed this and determined it wasn’t an inpatient case,” says the compliance official.

The hospital is now beefing up its inpatient documentation to try and survive Medicare Advantage and other audits, “but it’s hard to set standards” when auditors are disregarding nationally accepted admission criteria. And “the Medicare benefit policy manual isn’t specific. It just says physicians have to write down the risk and how the severity of comorbidities may influence this particular course of events.” Things can get dicey when trying to support one- and two-day stays, especially for diagnoses like syncope, chest pain, cardiac procedures, asthma, chronic obstructive pulmonary disease and congestive heart failure. “It will be harder and harder to show [the patient needed to be in acute care] because a lot of people are raising the [documentation] bar,” she says. “We’re lambs being led to the slaughter.”

Hospitals should keep in mind that Medicare Advantage plans can interpret Medicare rules differently than the fee-for-service side of the house, says Joe Zebrowitz, M.D., executive vice president and senior medical director of Executive Health Resources, a Philadelphia firm that works with hospitals on medical-necessity compliance.

For example, a Medicare Advantage plan can stipulate in contracts that all patients kept in the hospital fewer than 24 hours be assigned a status of outpatient with observation services. And Medicare Advantage plans can design their own utilization-review programs. However, “hospitals have not agreed to provide care per the opinion of a single physician working at a managed care plan. They have agreed to provide care by contract under a reasonable standard of care,” Zebrowitz said in February 2010. And InterQual and Milliman are nationally accepted guidelines. “It would be very hard for a physician to argue that his or her judgment is sufficient to countermand the high bar of admission that is set by nationally accepted screening criteria — criteria that are utilized as a standard by every MAC in the country,” he notes.

Sepsis Prone to Vague Documentation

RAC officials at CMS have made it clear that InterQual and Milliman don’t offer blanket immunity from medical-necessity challenges to inpatient admissions. InterQual itself asserts the product just serves as guidance to be used by nonphysicians and that the criteria alone does not constitute an admission decision.

National Government Services (NGS), the MAC for 10 states, explains on its Web site that InterQual “evidence-based criteria...help users make decisions about individual patients’ progress through the health care continuum, and are intended to supplement and support the physician’s own knowledge base. InterQual criteria were never meant to take the place of physi-
cian decision-making. InterQual...is used both within facilities and by Medicare contractors. Providers use it to assist in choosing appropriate patient placement; contractors use the criteria to review appropriate placement when auditing medical records. However, the physician has the patient in front of him/her and uses patient presentation along with these tools to make clinical, patient-focused decisions. Not every patient fits neatly into a technical, automated impersonal process.”

Documenting risk to the patient is part of satisfying medical necessity objectives. Physicians are required to describe severity of illness and intensity of services in the chart to make the case for an inpatient admission. InterQual puts a patient’s case through a severity of illness/intensity of service filter, but only documenting the phrase “meets InterQual” won’t do the trick.

Andrew Rothschild, M.D., an Austin, Texas-based associate director for Navigant Consulting, says the documentation pattern emerging in claims denials is a lack of evidence that the patient was really sick. “Documentation doesn’t show that the patient was sick — even if they were. Alternatively, patients who clearly appear severe have no documentation supporting what acute care services are being provided by the hospital,” he says.

**Sepsis Requires Elaboration**

Sepsis is vulnerable to auditor slash and burn, Rothschild says. “Patients can be devastatingly ill with documented sepsis, but if there’s no charted evidence that the patient was sick,” the claim may be denied, he says. He recently reviewed a baffling denial involving sepsis, under which ‘the director of the health information department showed me the chart, and every doctor in the chart said ‘sepsis.’ But they were all poor documenters. The chart said the word ‘sepsis’ and they ordered antibiotics and had even consulted with infectious disease physicians,” which is unusual in this circumstance, Rothschild says. “They clearly thought it was sepsis, but they neglected to say why. What were the physical exam abnormalities or the abnormal tests? Because there was no documentation that the patient was very sick, the Medicare auditor wanted more.”

The chart should be descriptive — “patient appears pale, febrile, diaphoretic, lethargic, slow to respond, elevated WBCs” — anything that supports that the history and physical exam are consistent with sepsis, Rothschild says. If you gloss over signs and symptoms, auditors wonder why.

Rothschild called the Medicare reviewer and asked what was missing from the chart. After all, the doctors ordered antibiotics and an infectious disease consult. The physician-reviewer responded, “Well, it just doesn’t look like sepsis to me.” Rothschild couldn’t believe that’s all the feedback he received. Hospitals need rules and standards to live by. However, in the letter denying the claim, the reviewer said while Medicare wouldn’t pay for sepsis, the hospital was welcome to revise the claim and re-submit, which is better than nothing.

Rothschild warns that RACs are playing games with the definition of “excisional debridement” and its documentation standards. During the RAC demonstration, RACs denied claims for the CPT code 86.22 — which is the surgical procedure excisional debridement — if the surgeon failed to write the magic word “excisional” in the chart. But now RACs are challenging claims even when the word excisional appears and all other criteria are met. The nurse-reviewer explained her reasoning: “How do we really know the surgeon excised the tissue? We need reasonable evidence, such as depth of incision, technique, instrumentation, or similar.” But Rothschild and David Schimel, president of National Health Resources in Great Neck, N.Y., say neither Coding Clinic, the manual published by the American Hospital Assn., nor CMS regulations make reimbursement of excisional debridement contingent on this detailed documentation.
“It’s helpful to be specific because RACs want proof,” Rothschild says. But it’s not always easy. Take the diagnosis of “empiric sepsis.” It’s called empiric sepsis versus sepsis because the physician has no evidence yet of the diagnosis, but it’s pretty obvious based on the physician’s experience that the patient’s signs, symptoms and exam are consistent with sepsis. In this environment, however, “take my word for it” will not suffice as documentation. So Rothschild suggests using documentation like this: “culture is negative in-house, white blood cells mildly elevated but initial cultures outpatient were positive, patient’s physical exam and outpatient cultures are consistent with empiric sepsis.” Rothschild says “I don’t think the RAC would argue with that.”

Evidence-Based Method Is Documentation Tool

The tendency of physicians to jot down their opinions rather than document auditable data makes it harder for hospitals to survive audit scrutiny, says Becky Cornett, director of fiscal integrity at Ohio State University Medical Center.

Physicians don’t write in “audit speak,” she says. “Everyone you call in hospitals — compliance and utilization review and quality directors — says they wish physicians would write the correct stuff.” That means physicians should chart the complexity of medical decision making and correlate it to the risks of adverse events that patients face if they leave the hospital, the severity of signs and symptoms, the predictability of a patient’s clinical course and the physician’s thinking about the patient’s risk indicators. “But it doesn’t seem to be intuitive to them,” Cornett says. “They can write a narrative but they should get away from their opinion and move toward evidence-based criteria and guidelines.”

In fact, she thinks hospitals should use evidence-based medicine as a documentation tool. For example, the Charlson Comorbidity Index can be downloaded into a PDA or printed out on paper for the physician to bring on rounds. When documenting in a patient’s medical records, physicians can enter the patient’s complications and comorbidities and how they make the person vulnerable and in what way the inpatient admission reduces the danger to the patient. How can an auditor argue with that?

Other Tools Can Be Used Also

Similarly, Fine’s Criteria for community-acquired pneumonia is a relatively simple tool that can be adapted for documentation purposes. It’s an objective method for determining whether a patient’s presenting condition warrants inpatient admission. If the physician documents use of the Fine Criteria to determine inpatient versus observation setting, presumably they have established medical necessity.

The American College of Cardiology also has extensive guidelines on severity factors and appropriate procedures for different settings according to risk indicators, Cornett says. And that’s just to name a few.

There’s another angle to the InterQual issue. If hospitals find that their inpatient admissions are denied despite having met InterQual criteria on first-level review, it’s possible that “the hospitals don’t have a consistent first-level review process,” Zebrowitz says. In other words, maybe they are not using InterQual appropriately. He says it’s “no easy feat.” Case managers have to be well-trained and there must be inter-rater reliability, which means that the tool is used in a consistent way, no matter who is applying the criteria.
A Lot Rides on Quality of InterQual Reviews

Hospitals should make it a point to regularly perform inter-rater reliability testing on all case managers and any other groups within the hospital who are involved in the utilization review process to ensure a consistent process is in place. If an admission fails InterQual, it should be referred to a physician advisor for second-level review.

Another hazard to watch for: When MACs or RACs do an InterQual review, they might not look as closely at the chart as hospital personnel, Zebrowitz says, a fact that can jeopardize the standing of your hospital’s claims. As an equalizer, he recommends that hospitals include InterQual reviews in the medical records they submit to RACs and MACs, which serve as a roadmap.

“If I’m a case manager working with doctors, I get familiar with the doctor’s terminology and their handwriting. But an auditor who has never seen that doctor’s handwriting may have a hard time with legibility. If the auditor is able to decipher what the doctor is writing,” it can make a big difference, he says. Conversely, if the auditor is thwarted in efforts to decipher documentation and interpret the significance of test results, the auditor may throw up his or her hands and deny the claim. “We reviewed and appealed plenty of cases during the RAC demonstration project that were denied despite clearly meeting InterQual. But you had to really dig through the chart to find the relevant information. By placing your InterQual review on the chart, you are demonstrating your process to the auditors and providing them with the information they need to approve the case,” Zebrowitz says. ♦

Hospitals Grapple With DRG Bundling of Nondiagnostic Services; Policy May Change

Hospitals are facing a logistical, compliance and public relations challenge over a longstanding feature of the DRG window unbundling rule because they have been, in a way, too compliant. Fixing the problem may be lucrative, but it also may be a billing and coding nightmare. However, there are hints that CMS may modify the DRG window unbundling rule.

Since the government cracked down on DRG window unbundling in the 1990s, many hospitals have rolled into Medicare inpatient claims all the outpatient services provided during the three days before the patient’s admission. That’s fine for diagnostic services, because bundling them into the DRG has been a no-brainer since the implementation of a 1991 regulation. But the billing rules for outpatient nondiagnostic services provided within three days of admission are trickier. Hospitals should bundle nondiagnostic services into inpatient claims only if there is an exact, five-digit match between the principal diagnosis code for the outpatient services and the principal diagnosis code for the inpatient stay, according to CMS’s 1998 revision to the DRG window unbundling rule.

Many hospitals, however, have bundled everything. And now they are waking up to their noncompliance (or ultra-compliance). “We were bundling all this stuff all these years, and no one said anything,” says the director of patient financial services at one hospital, who asked not to be identified. “It puts another layer of complexity in the whole three-day window rule. I don’t think we have dealt with this before.”

CMS and its Medicare contractors are waking up too, and there are hints that a policy change may be forthcoming. For example, First Coast Service Options, the Florida-based Medicare
administrative contractor (MAC), is “currently re-examining this policy and how claims are handled within the CMS standard system,” an official with the MAC told AIS in February 2010.

Hospitals find the five-digit match requirement at odds with the real world. In emergency departments (EDs), operating rooms (ORs) and observation beds around the nation, patients are routinely diagnosed with something different from the ultimate diagnosis that precipitates their inpatient admission. For example, when patients come to the ED for chest pain and are admitted, and then it’s determined that they’re having a heart attack, the principal diagnosis codes won’t match (chest pain and myocardial infarction have different ICD-9 diagnosis codes). That means hospitals can unbundle the ED visit from the DRG and collect an APC payment.

Some Hospitals Have Not Billed Separately

But apparently, many hospitals have not been billing separately for nondiagnostic ED, OR and observation services when the principal diagnosis codes don’t match, despite the regulatory requirement. And CMS and its Medicare contractors either went along with the noncompliance or never noticed it.

Some hospitals may not have been aware of the 1998 clarification. And some hospitals felt safer bundling everything after the Department of Justice/HHS Office of Inspector General DRG window unbundling initiative, when hospitals made repayments or settled cases for unbundling diagnostic services from DRGs, says one compliance officer, who asked not to be identified. “We were burnt severely by the enforcement. And we had already implemented [billing] systems at all our hospitals to comply with the regulations before they came out with the [1998] change to the regulation that said you only have to roll in those primary diagnosis codes for the encounter that matched,” says the compliance officer. “There was no way to manage it. So we threw up our hands and said, ‘Screw it.’”

Now it appears that compliance — for both past and future claims — may be rewarding. There is money to be captured by rebilling past claims that have been erroneously bundled, according to the consultants who are hawking their services to hospitals. In fact, consulting firms, including McBee Associates of Wayne, Pa., appear to have gotten everyone hot and bothered about the inappropriate bundling in the first place.

Meanwhile, CMS and Medicare contractors have been asked to shed light on the five-digit match. For now, at least, the answer is yes, hospitals should abide by the diagnosis-code matching requirement — but there seem to be cracks in this stance. And some Medicare contractors aren’t taking the regulation at face value. Mary Hairston, the manager for Medicare audit and reimbursement at National Government Services (NGS), the Medicare administrative contractor for 10 states, asked CMS in an e-mail for clarification of bundling rules in circumstances where ED, OR and observation services morph into inpatient services. “I have been advised that CMS is discussing internally how to handle claims within 72 hours that do not have a break in service,” Hairston said in the November 2009 e-mail. In other words, when there is no separation of service — the patient is swept from the ED, observation or OR to the inpatient bed — can the outpatient services be charged to Medicare?

In response, CMS official Valerie Miller cited the relevant policy, which appears in the Medicare Claims Processing Manual, Chapter Three, Section 40.3. “Nondiagnostic outpatient services that are related to a patient’s hospital admission and that are provided by the hospital or by an entity wholly owned or wholly operated by the admitting hospital…to the patient during the 3 days immediately preceding and including the date of the patient’s admission are deemed
to be inpatient services and are included in the inpatient payment...we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay.” The CMS official added that the manual makes no distinction between services that are separated and nonseparated.

Some Medicare contractors’ doubts about the policy are manifesting on the payment side as well. One MAC suspended a few claims submitted by a hospital that is trying to collect reimbursement on outpatient services it had improperly bundled into the DRG. The MAC explained that “we are asking CMS for guidance as to whether or not CMS Pub. 100-4, Chapter 3, Section 40.3 [on the five-digit match] is intended to apply to preadmission services rendered in the emergency room when the Medicare beneficiary is then admitted as an inpatient that was not previously admitted.”

**Beware Upcoding Risk as Well**

Meanwhile, the jury is still out on how much hospitals will gain from rebilling the claims. But the process is not costing them any money. A number of consulting firms are offering to help hospitals — on a contingency basis — unbundles and rebills outpatient services when their principal diagnosis codes don’t match the inpatient admission’s principal diagnosis codes. One hospital that has used the services of Deloitte Development LLC rebilled from October 2007 through 2008 and is getting ready to work through the unbundled claims for 2009. “We adjusted the inpatient bill and rebilled the outpatient part that did not match so we can be compliant,” a hospital billing manager says. “For the most part, the DRG stays the same, but you get the ED payment.”

However, sometimes the noncompliant bundling may have triggered a higher-paying DRG, which means the hospital will have to repay Medicare. “If you do not pull those outpatient nondiagnostic services out, but rather leave them, along with their associated procedure and/or diagnosis code(s) on the inpatient claim, your facility may be erroneously increasing payment under the inpatient prospective payment system (IPPS) under which acute care hospitals are paid,” NGS said in a December 2009 teleconference. If, for example, a patient comes in for outpatient surgery, but complications force an inpatient admission, the DRG may be upgraded to surgical, which pays more than a medical DRG.

**RACs and OIG Are Targeting Issue**

Because revisiting the five-digit match unbundling issue could uncover upcoding as well as underbilling, the end result may be a wash for hospitals financially, the billing manager says. But it’s a risk worth taking because the consulting firm is paid a percentage based only on the money recovered, she says. Presumably the upcoding angle is why two recovery audit contractors (RACs) — CGI Federal and HealthDataInsights — and OIG are targeting DRG window unbundling.

Going forward, the hospital will unbundle the outpatient services without the matching principal diagnosis codes, so rebilling will be moot. That’s the only route another compliance officer thinks hospitals should take. “Hospitals have missed an opportunity to receive Medicare APC payments for services that don’t have an exact match to the inpatient’s principal diagnosis at discharge, but retrospectively adjusting claims may open another can of worms,” the compliance officer says. The reason: A separate claim for the outpatient service will mean a separate copayment. “CMS may rule that this harms beneficiaries because they have financial liability for an outpatient claim they were totally unaware of,” the compliance officer says.
Now that the unbundling Pandora’s box is open, hospitals have to compare outpatient and inpatient claims for the five-digit ICD-9 principal diagnosis code match. The bottom line: “It requires a new level of analysis,” says Rick Snyder, vice president of finance and information services at the Oklahoma Hospital Assn. “It...will probably require comparing the outpatient documentation with inpatient documentation to see if they have the degree of matching that would make the bundling appropriate.” Bundling may or may not change the DRG assignment, he notes.

Some hospitals are shellshocked by the hassle of it all. “The problem is, when these services are combined, as in an ED visit, the ED visit is never separately coded,” says Mic Sager, compliance officer for Olympic Medical Center in Port Angeles, Wash. If patients are admitted as inpatients from the ED, coders don’t separately code the principal diagnosis of the ED services, which obviously makes it impossible to evaluate whether there is a five-digit inpatient/outpatient match.

Sager has worked at four hospitals, and none of them coded ED services as stand-alone services when patients were admitted. “It’s always been just documentation for the inpatient coders,” he says.

RACs Are Requesting Physician Queries; CMS Says Their Submission Is Not Required

Concerns are being raised about medical-record requests from recovery audit contractors (RACs) conducting MS-DRG audits. Several RACs want physician queries from hospitals, which comes as a surprise because some hospitals do not maintain queries or don’t consider them part of the legal medical record, compliance officers said in March 2010.

Hospitals fear that RACs may deny their claims if queries aren’t submitted, and are unsatisfied by the RAC response to the query anxiety. But a top CMS RAC official indicates that RACs should not require physician queries.

On a different front, one expert notes that hospitals in the practice of saving “concurrent” queries will stand the best chance of proving query compliance and preserving appropriate reimbursement.

The medical-record requests pertain to RAC audits of certain MS-DRGs, says Cheryl Rice, vice president and chief corporate responsibility officer for Ohio-based Catholic Healthcare Partners. The RACs are apparently reviewing whether documentation supports the principal and secondary diagnoses assigned by hospital coders or whether they were inappropriately assigned, resulting in upcoding. Queries may be part of the RAC review because of longstanding CMS fears that leading queries prompt physicians to diagnose in the direction of more lucrative DRGs.

Connolly Healthcare, the RAC for Region C (Texas, New Mexico, Florida, Georgia, Virginia, West Virginia, Louisiana, Mississippi, Oklahoma, North and South Carolina, Alabama, Arkansas, Colorado and Tennessee), has been sending hospitals letters demanding these “applicable components of the medical record and/or other documentation” to support payment of these claims:

◆ Face sheet
◆ Discharge summary
◆ History and physical
◆ Emergency room records
◆ All nursing notes
In a letter to hospitals, CGI Federal, the RAC for Region B (Indiana, Michigan, Minnesota, Illinois, Kentucky, Ohio and Wisconsin), similarly demands “components of the medical record and/or other documentation to support payment of this claim.” While the letter is a bit ambiguous, Rice notes, CGI wants the “entire medical record” and then lists the following:

- Physician query
- Face sheet
- Discharge summary
- History and physical
- Emergency room records
- All nursing notes
- ER nursing notes
- Consultations
- Physician orders
- Therapy treatment plan and notes
- Physician progress notes
- Lab, radiology, operative and pathology reports
- ICD-9-CM diagnosis codes submitted
- UB 04 or HCFA (CMS) 1500 claim forms
- Medication administration records.

Rice has spoken to compliance officials at dozens of hospitals, who say they are surprised that RACs expect hospitals to produce physician queries and alarmed by the obstacles to complying.

Andrew Rothschild, M.D., associate director for Navigant Consulting, contends the RACs should clarify what types of queries they are requesting. According to AHIMA, “concurrent queries are initiated while the patient is still present. Retrospective queries are initiated after discharge and before the bill is submitted.”

Rothschild raises the question of whether RACs want retrospective coding queries, which are commonly retained in the chart. If not, then which queries? Many hospitals have multiple sources of provider queries for a variety of reasons — some are retained in medical records or elsewhere, others are discarded — a reality supported by CMS, Rothschild notes.
Many Inpatient Cases Don’t Warrant Queries

He also says that only about 40% of inpatient cases warrant queries for additional physician information. Since the goal of physician querying in terms of documentation improvement is to get more and complete information, individual queries may or may not directly impact coding, and therefore may or may not be relevant to RACs, Rothschild says.

Even when necessary, queries aren’t a formal part of the legal medical record. “The physician query is purely meant to be a communication tool” between coders and physicians, Rice says. “The expectation is that the physician would then go back into the patient’s medical record, look at the progress notes, understand why the coder is confused and then do an entry that is separate to make a clarification,” Rice says.

Because queries are a tool, some hospitals do not retain them. “Some hospitals have retention policies that say once the physician makes a clarifying entry in the medical record, that query is destroyed after a certain period of time,” Rice says. It’s not a disappearing act; the hospital puts a note in the medical record stating the coder asked the physician to flesh out the diagnosis. “It is putting us in a difficult situation about what will be sent in and reviewed,” she asserts. Some hospitals retain queries but don’t consider them part of the legal medical record. They also don’t feel duty-bound to turn over queries to the RAC.

Neither of the RACs for Regions B and C offers hospitals a vehicle for conveying that they didn’t query in a particular case or don’t retain queries, Rice says.

This is scary stuff for hospitals, because claims can be denied if Medicare auditors determine a hospital has supplied “insufficient documentation” during a review. However, if the hospital disposed of the query, there’s nothing it can do.

But CMS says RACs cannot be rigid about queries. “The provider can only give what it has in the case file,” Connie Leonard, CMS’s director of the Division of Audit Recovery Operations, tells AIS. “The RACs place it on the request [for medical records] because they want to be sure the provider is sending everything that they have on that claim/stay. A RAC should not be saying it is required. A provider can only submit the information that it has on hand.”

That will come as a relief to hospitals, which so far haven’t made much headway getting consistent or logical answers on this question directly from the RACs, Rice says. In response to one query, a RAC customer service representative insisted the physician query must be included in the materials returned to the RAC, she says. Other times, hospitals got different answers.

RACs Have Not Given Consistent Answers

“We have had some of our facilities told that they must send the query if it is part of the medical record,” Rice says. “Other facilities were told ‘it’s up to you whether to send it.’” Hospitals have also been told that “at a minimum, your submitted document should include the documents listed, but more can be provided” and “all documents in your legal medical record should be provided including the specific documents outlined to meet the entire medical record.”

It’s disconcerting for hospitals to get conflicting answers from within the same RAC. But that’s what happens sometimes when a hospital reaches different customer service representatives at the same RAC, Rice says. “Maybe they need to get their people scripted,” she says. “Hospitals are trying to comply with the medical-records request, and our issue is, we get mixed messages and inconsistent messages and people are like, ‘I didn’t get that answer when I called before.’”
Rothschild cautions hospitals against destroying queries in case they need to vindicate their coding assignments. “Hospitals querying compliantly should be more than happy to provide their queries, because they support that everything was done correctly and that claims should be paid,” he says. When a query provides sufficient evidence for the reason coders are querying and asks open-ended questions about diagnoses, it gives the RAC further evidence the coded diagnoses were right.

“On the other hand, if the hospital is querying inappropriately — like when there is insufficient evidence that a query was warranted — this could give the RAC plenty of reason to deny payment. And you can bet the OIG would be knocking at the door if trends indicated RACs were denying due to noncompliant querying. It would smell a lot like Medicare fraud,” Rothschild says.

Even if queries are 100% compliant, quickly throwing them out smells of deception, Rothschild says, particularly in the current environment, where CMS has made it clear that it’s concerned about noncompliant, leading queries. However, he recommends that hospitals keep concurrent queries separate from the medical records (e.g., in a locked filing cabinet in the HIM department).

How long should hospitals maintain queries? Half of the hospitals Rothschild has worked with keep queries for “a very short time” and “half keep them for a reasonable amount of time,” which he hesitantly estimates as a year or two, while noting that guidance is really lacking in this area.

Rothschild says queries are often sought because CMS and other agencies increasingly want more specific documentation. For example, even when physicians have already documented a sepsis diagnosis, coders may query physicians for “supporting logic or reasoning if the diagnosis doesn’t clearly and logically follow the documented information,” Rothschild says.

In some cases, such as excisional debridement, RACs tell hospitals they must produce more documentation than what is required by regulations or other formal guidance.

**CMS: ‘Queries Should Not Lead MDs Astray’**

“The government wants both more details and more evidence to justify certain diagnoses. I now tell physicians to add their reasoning to any diagnosis that they think could be refuted or that may not innately make obvious clinical sense, such as pneumonia with a negative X-ray and without fever” — even if there are solid grounds for this diagnosis, without specifying the reasoning. RACs will likely look for a query to see if the coder was leading the physician astray.

It’s essential for physicians to explain themselves when diagnoses seem improper, even if they’re not. If clinical logic is lacking for a diagnosis, coders or clinical documentation improvement specialists should ensure that physician queries appropriately elicit clinical support (i.e., Afebrile, but 104.2 at home; despite negative X-ray, significant left lower lobe rales/rhonchi indicate empiric pneumonia). Pneumonia with this statement should not be denied, Rothschild says. (Of course, the next logical query is for which type of pneumonia; there’s always another query, Rothschild says.)

“The RAC likely wants to see if there was a query that was blatantly leading the physician to that diagnosis since there was no clinical evidence” or if the diagnosis, and therefore the coding, was supportable, he says. ✤
Looking Forward: RAC Trends

Enforcers Have More Funds, Better Tools to Fight Overpayments, Fraud

The twin engines of enforcement and guidance are revving up as the 2010 started to unfold. Medicare program integrity auditors of different stripes were ramping up, False Claims Act cases continued at a fast pace and HHS and the Department of Justice were flexing their combined anti-fraud muscles, while CMS planned to intensify efforts to articulate Medicare billing and documentation standards.

A phenomenal amount of activity was taking place in the enforcement and program integrity arenas. Zone program integrity contractors (ZPICs) — CMS’s data-driven fraud and abuse hunters — began audits in Texas, Oklahoma and New Mexico, says former Texas Medicaid Inspector General Brian Flood. The ZPICs, which do intense reviews, are focused now on short hospital stays and durable medical equipment, says Flood, now managing director with KPMG. “Providers will feel the touch of the government more often,” he said in January 2010.

Recovery audit contractors (RACs), which began coding and DRG validation audits, will also ratchet up scrutiny in 2010. Connie Leonard, director of the CMS Division of Recovery Audit Operations, told AIS in January 2010 that CMS had given one RAC (for Region D) the green light to do probe audits for complex coding and medical necessity. Probe audits, which are mini-audits that indicate whether an area is worth delving into further, are the first step toward the complex medical reviews that providers dread because of their potentially devastating financial consequences.

“Later on [in 2010], we expect to let RACs do medical necessity [audits],” Leonard says. But perhaps the most controversial RAC audits — which challenge the site where a service is performed (e.g., inpatient vs. observation) — won’t be tackled during this first round of medical-necessity probe audits, Leonard notes.

Meanwhile, the Department of Justice will keep churning out fraud cases, and compliance officers and lawyers expect more of them to focus on hospital-physician relationships and quality of care. The combined forced of DOJ-HHS in the Health Care Fraud Prevention and Enforcement Action Team (HEAT) will become an increasing threat. “You have the current administration putting $311 million into HEAT [and other Medicare and Medicaid program-integrity activities] for fiscal year 2010, which is 50% more than [2009],” says Washington, D.C., attorney Paul Danello, with Baker & Daniels. “Obama is projecting in his budget that over the next five years, [the anti-fraud efforts] could save $2.7 billion that was illegally paid to providers. That will come out of the skin of hospitals and physicians.”

And innovative uses of data mining and analysis will make all the auditors, investigators and enforcers more effective in identifying fraud and abuse and overpayments. “There are so many different characters in this compliance play and they are so much more coordinated than we have seen before,” says San Francisco attorney Judy Waltz, with Foley & Lardner. “They are looking at so many more issues.”

For health care organizations frustrated by the complex and sometimes convoluted Medicare rules, there will be some relief in 2010. George Mills, director of the CMS Provider Compliance...
Group, which includes medical review, data analysis, error rate measurement and the RACs, tells AIS that more education on specific risk areas is in the works. “We will be issuing guidance and having open door forums on documentation issues we are seeing that are clearly preventable,” Mills says. “What we are trying to do is chop it into digestible pieces.” Among the topics: admitting patients versus ordering observation services; fixing medical records to address problems identified in OIG reports; and addressing errors identified by CMS’s comprehensive error rate testing (CERT) contractor (e.g., missing and illegible signatures). Mills adds that the RAC team will tape training sessions and put them on the Web.

‘Good Year for False Claims Act’

Predicting heightened enforcement isn’t just an annual ritual. The money is now there to back up the words. “I see an uptick in everything — there will be increased enforcement, more whistleblower cases and more investigations because more resources are available,” says former top DOJ attorney John Kelly, now with Fulbright & Jaworski.

“It’s going to be a good year for the False Claims Act,” says Pat Burns, spokesman for Taxpayers Against Fraud. “We are on a good trajectory already.” For example, some major pharmaceutical companies are setting aside hundreds of millions of dollars to settle allegations involving off-label marketing of drugs, he says. The enormous fines and recoupments keep the DOJ and HHS war on health fraud and abuse churning; the funds are recycled back to them through the federal government’s Health Care Fraud and Abuse Control program.

A settlement of the false claims lawsuit against Christi Sulzbach, former Tenet Healthcare Corp. chief compliance officer and general counsel, is also expected in 2010, Burns says. “That will happen this spring because both sides moved for summary judgment” in spring 2009. In the unprecedented case, the U.S. attorney’s office in Miami accused Sulzbach of helping a Tenet hospital in Florida collect undeserved Medicare reimbursement. According to the complaint, Sulzbach twice signed corporate integrity agreements attesting to the hospital’s compliance with all legal requirements even though she allegedly knew some hospital-physician contracts violated Stark physician self-referral rules. Sulzbach’s attorney has called the allegations wrong both “legally and factually.”

In the provider arena, relationships with referral sources will attract more enforcement actions. “Everyone should look at issues around physician arrangements,” says Susan Walberg, corporate compliance officer for MedStar Health, which has hospitals in Maryland and Washington, D.C. “This area is gathering steam.” It’s not enough to have a contract in place for administrative services, such as medical directorships, she notes. Health care organizations should ensure they possess documentation to support payments and to show that physicians actually provided services for which they are compensated.

Mark Pastin, president of the Council of Ethical Organizations in Alexandria, Va., also sees physician arrangements as a false claims growth industry. The increasing risk means compliance officers should examine them in greater detail. First, “compliance officers are often kept away from this topic; they are told that legal handles it,” he says. This hands-off attitude may stem from management’s fear that compliance officers see the world in black and white and will veto too many deals.

Second, there are more false claims lawsuits built around Stark and/or anti-kickback violations. These types of lawsuits “are particularly appealing to physician-whistleblowers who feel that other physicians are being treated more favorably. And since it is the natural condition of
physicians to feel other physicians are treated more favorably, we are seeing a lot of these allegations,” Pastin says. Compliance officers will have to “break down the wall to legal to do their job.”

**Hospitals to Grapple With Self-Discovered Errors**

And with compliance officers more effective at investigating complaints than they were five years ago, they are more likely to identify problems and try to resolve them. “What makes this all work” is when senior management supports necessary corrective action in response to compliance officers reporting problems, Pastin says. Otherwise, compliance officers could become a source of whistleblowers.

Whether or not they are DOJ targets, “a lot of hospital systems will have to deal with their own internally discovered Stark noncompliance,” says Denver attorney Jeffrey Fitzgerald, with Faegre & Benson. With the prevalence of mature compliance programs, hospitals over the next two years “will be developing a process for resolving Stark hiccups.” For example, if they have a physician contract that expired and wasn’t signed immediately, there is an alternate path to compliance that doesn’t require disclosure to the government. But hospitals need procedures to address near misses and violations.

HEAT is increasingly a force to be reckoned with. It marshals the combined administrative, civil, criminal and asset-seizure powers of DOJ and HHS in the war on fraud and abuse, Kelly says. “They are trying to brand their health care fraud initiative,” he says. The strike forces in Tampa, Baton Rouge, Detroit, Houston, Los Angeles and Miami are only one part of HEAT. Already numerous civil and criminal cases are attributable to HEAT. For example, HEAT gets credit for DOJ’s December 2009 settlement with Mercy Medical Center in Sioux City, Iowa. The hospital agreed to pay $400,000 to settle a false claims allegations that it inflated charges for heart patients’ care to trigger Medicare “outlier” payments, according to the U.S. attorney’s office in Cedar Rapids.

HEAT and other health fraud enforcers will thrive in the coming years due to recent changes to the False Claims Act in the Fraud Enforcement and Recovery Act (FERA) of 2009, Danello says. For example, FERA established explicit liability for retention of Medicare overpayments, extended the statute of limitations and significantly changed the definition of a “claim,” among other things. The effect of a more potent FCA in the hands of enriched HEAT will be “a game changer” for 2010, Danello says. “The game is running highly in favor of DOJ and whistleblowers and highly against hospitals and other providers.”

Expect OIG and the Department of Justice to pursue more quality-related False Claims Act cases and other enforcement actions in 2010 and beyond, says Los Angeles attorney Cheryl Wagonhurst, with Foley & Lardner. Health care organizations may be hit for allegations of medically unnecessary services; services not rendered, not rendered as prescribed or for substandard care that rises to the level of a failure of care; never events (serious medical errors); unreliable hospital-reported quality measurement data; and flaws in Medicaid statistical information system data reporting, she says.

“A quality-of-care enforcement action is probably the worst kind a provider can imagine. It has far greater ramifications than a Stark or kickback action” in terms of the impact on a provider’s reputation and stock prices, Wagonhurst says. The OIG 2010 Work Plan also puts a “significant focus on quality of care” and the integrity of data reporting, she notes. DOJ announced a major criminal and civil settlement with a nursing home chain over substandard care. Wagonhurst says
the government has made it clear that quality of care enforcement actions will expand to other types of facilities.

**Pressure to Reduce Errors Will Filter Down**

Pressure is building to reduce payment errors since the Obama administration announced in November 2009 that the Medicare fee-for-service error rate doubled to 7.8% between 2008 and 2009, Waltz and Wagonhurst say. CMS has made it easier to reject claims based on flaws that it may have tolerated in the past, the lawyers say. For example, a patient’s history can’t be used to compensate for documentation gaps; missing or illegible signatures will no longer be tolerated. Also, President Obama issued an executive order that requires a reduction in improper Medicare and Medicaid payments.

Waltz and Wagonhurst say these developments — and a 2009 report by Thomson Reuters citing $700 billion worth of waste annually across the U.S. health care system (e.g., unnecessary care, fraud, inefficiencies) — will perpetuate an already powerful recoupment trend.

RACs are already gunning for payment errors, but it will be a new experience for hospitals to face ZPIC auditors. Flood says that ZPICS, which will be auditing in all states by the end of the year, are a different animal than RACs. They visit hospital-targets in person, “and expect nearly instantaneous access to your medical records,” he says. So far, CMS hasn’t capped the number of medical records that ZPICs can demand from hospitals, or limited the number of years of claims they can audit, Flood says. In one case, the ZPIC showed up at a hospital asking for 200 medical records. After the hospital explained its limitations, the ZPIC gave the hospital 30 days, Flood says.

But these contractors focus on egregious conduct — “considerable abuse or fraud,” Flood notes. ZPICs get data-mined referrals from CMS, and then conduct coding, overutilization and medical-necessity audits. When there are potential cases of fraud or abuse, they will be referred to OIG and DOJ.

**Medicaid Is a Growing Risk Area**

Medicaid program integrity auditors also are building up momentum. Several states now have Medicaid inspector generals, a sign that states are ramping up their war on Medicaid fraud and abuse. The states are New York, New Jersey, Kansas, Texas, New Mexico, Florida, Georgia and Illinois, according to Waltz and Wagonhurst.

New York Medicaid Inspector General Jim Sheehan is capitalizing on data mining and analytics to identify aberrant billing patterns and other undesirable activity. “Data mining is getting better all the time,” Sheehan says. “More information sources are being added” — including death data from the Social Security Administration, vital statistics and hospital discharge data — to Medicare and Medicaid databases. HHS Inspector General Daniel Levinson told Congress in June 2009 that the “integrated data repository” being constructed by CMS will “contain a wealth of data” that cuts across several CMS programs.

**Ineligible Docs: ‘Where Are They Now?’**

For example, New York’s Office of the Medicaid Inspector General (OMIG) has a data-mining project underway called “Where are they now?” It’s designed to identify the location of physicians who have been kicked out of Medicaid in another state to ensure they can’t get a new provider number under a different name (or to identify if they are already billing under a legitimate provider’s number). “There are ways to track them even [when they are] using a fake identity,” Sheehan says. It’s called entity analytics — “when people disappear from the grid, they don’t change everything. Maybe they change their first name, but certain things are predictable” (e.g., using their mother’s maiden name as a new last name).
Sheehan says that during 2010, OMIG would focus more on the effectiveness of compliance programs, which are mandatory for hospitals and many other Medicaid providers in New York state. “[2009] was about getting a compliance program up and running. This year we’ll be working with provider groups on how it’s running,” he says. For example, Sheehan wants to confirm that organizations check employees for Medicare and Medicaid sanctions and other black marks, and make sure screening is done well. Sheehan says many organizations use vendors to perform screening, but they may not check both state and federal sanction lists. “We know there are problems,” he says. There are 6,000 people currently excluded from New York Medicaid and their names are posted on OMIG’s Web site. But Sheehan says organizations must ensure that trained, competent people use the tool properly or the effort won’t do much to promote compliance.

With all the pressure from the government, health care organizations will have to leverage hospital resources to compensate for compliance budgets that don’t grow fast enough, says Roy Snell, CEO of the Health Care Compliance Assn. “Get people outside the compliance program to help with compliance,” he says. For example, internal auditors may conduct a whole slew of audits that never approach legal or regulatory issues, and they can be solicited to spend some of their time in the compliance arena. “Befriend them and get them interested in [compliance] audits,” Snell says. “It’s not against the law to pay a vendor twice,” but large RAC recoupments, false claims lawsuits or Medicare exclusions are significant body blows to organizations.

EMRs: A Brave New Compliance World

Finally, a major new challenge for compliance officers in the coming year will be adapting their monitoring and investigation skills to electronic medical records. With electronic systems, “it’s hard to tell if a code or documentation was changed before or after a claim was rejected,” Pastin says. White-out used to be the tool of choice for documentation manipulation — false claims lawsuits have cited charting parties as evidence that providers tampered with records — but that is moot with EMRs. For example, “a lot of health plans are assigning codes to various complaints and not preserving the original written documents. All of a sudden, that basic un-fungible data are turned into something that can be easily manipulated,” Pastin contends. “Some compliance officers don’t yet have the tools they need to replicate [with EMRs] what they have learned to do in the paper environment,” including auditing, monitoring and investigating.

Reform Law Requires Overpayment Returns, Compliance Programs for All Providers

Health reform legislation signed by President Obama on March 23, 2010 (H.R.3590) — coupled with reconciliation “fixes” enacted on March 25, 2010 (H.R. 4872) — provide an adrenaline shot for Medicare audits and enforcement.

Among other things, the landmark legislation provides for an additional $250 million to combat fraud and abuse, creates new federal enforcement tools, requires the return of overpayments, creates a new Stark self-disclosure process, and mandates compliance programs for all providers.

In other provisions of the new law, recovery audit contractors (RACs) will be expanding their reach. By the end of 2010, audits by the contingency-fee contractors will include Medicaid claims. States are required to hire RACs to identify and recoup under- and overpayments.
Washington, D.C., attorney Heidi Sorensen calls the RAC expansion “troubling.” For one thing, she thinks it’s a rush to judgment. “Personally I think they should have done three years of the [original] demonstration program before they evaluated whether to move forward with it,” she says. She points out that each state handles its Medicaid program differently, so this could turn into a gigantic mess.

The health reform law restores the self-disclosure process for Stark violations. HHS must create a Stark self-disclosure process within six months of enactment. It also lets the HHS secretary reduce the penalty for violating Stark according to:

1. The nature and extent of the improper or illegal practice;
2. The timeliness of such self-disclosure;
3. The cooperation in providing additional information related to the disclosure; and
4. Such other factors as the secretary considers appropriate.

“I think this is designed to address [2009’s] Open Letter from the Inspector General by creating a new vehicle for Stark disclosures and building in an ability to compromise recoveries which has hampered resolution,” says Sorensen. The HHS OIG open letter put an end to provider self-disclosures to OIG for Stark-only violations. Providers can still reveal Stark violations to OIG — and get the benefit of reduced penalties — but only if they’re paired with self-disclosures of kickback violations.

The False Claims Act got a hard-won clarification of nebulous language in its “public disclosure” section. According to the new law, the Department of Justice can object when courts dismiss claims just because the same allegations were publicly disclosed in federal hearings, congressional reports or investigations, or through the news media. Legislators have been fighting for this amendment for years, arguing it will resolve differences among federal courts. The federal government needs all the help it can get rooting out fraud, lawmakers say; lawsuits shouldn’t be dismissed because the same or similar information is contained in public reports.

Regarding kickbacks, the reform law clarifies that claims submitted to Medicare which include items or services resulting in violations to the anti-kickback statute constitute false or fraudulent claims. Another change clarifies that a person does not have to have specific intent to commit a violation.

**Much More Screening Required**

Under the law, HHS will establish procedures to screen Medicare, Medicaid and CHIP providers and suppliers by cross-checking state licensure organizations, criminal background checks, fingerprinting, unannounced visits, etc. (to take effect 180 days after enactment). New providers and suppliers could be subject to a period of enhanced oversight of 30 days to a year, during which they could be subject to prepayment reviews and payment caps.

The reconciliation amendments to the law (H.R. 4872) let the HHS secretary withhold payments to new durable medical equipment (DME) suppliers for 90 days when there is a significant risk of fraudulent activity among suppliers in a particular category or geographic area.

Providers and suppliers also will be subjected to increased disclosure requirements when they apply for Medicare enrollment or revalidation. They will have to disclose any current or previous affiliation with a provider or supplier who has uncollected debt, has been suspended or excluded from a federal health care program, or who has had billing privileges denied or revoked.
The law also lets HHS adjust payments of providers and suppliers who have past-due obligations to the IRS.

And providers and suppliers will have to establish compliance programs as a condition of enrollment in Medicare, in line with a timeline to be established by the HHS secretary. Sorensen says this has always been recommended and points out that providers in New York state are already required to have compliance programs in place. At the federal level, the Deficit Reduction Act mandated certain aspects of compliance programs, such as employee training requirements. So this is “building on what’s already been there,” she tells AIS.

**$250 Million Added to Fight Fraud**

Additionally, the legislation adds $250 million over the next 10 years to the Health Care Fraud and Abuse Control funds and integrity programs to fight fraud and abuse. Among the other integrity efforts, the reform law:

- Creates a data repository for CMS to match claims with agencies such as the Social Security Administration and Veterans Affairs to identify fraud and abuse.
- Requires that overpayments be reported and returned 60 days after they are identified.
- Withholds federal Medicaid matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System.
- Requires that orders for items or services be prescribed by a Medicare-enrolled physician or other eligible professional (for orders made on or after July 1, 2010).
- Requires physicians to maintain and provide upon request documentation for certifications for durable medical equipment and home health services, for orders made on or after Jan. 1, 2010.
- Requires physicians to have a face-to-face encounter with a patient before prescribing DME or home health services, for those prescribed after Jan. 1, 2010.
- Increases (to $50,000 for each false record or statement) civil monetary penalties for making false statements to federal health care programs or for delaying inspections, with these provisions applicable to acts committed on or after Jan. 1, 2010.
- Suspends payments during fraud investigations.
- Allows the HHS secretary to place a temporary moratorium on enrollment of new providers and suppliers in Medicaid if it’s determined that this will prevent or combat fraud, waste or abuse.