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

*Updated May 2011*

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

Since 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. Amid all the focus on the common risk areas, hospitals should also not lose sight of the importance of conducting self-audits of their organizations to catch errors.

Hospitals can expect to see a greater expansion of RAC audits in the future since states are required under the health reform law 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

RACs, PEPPER Set Sights on Pneumonia, a Long-time Risk Area for Hospitals

Medicare watchdogs are shooting their audit darts at pneumonia MS-DRGs, which are a risk area that just won’t go away. More than a decade after a national enforcement initiative led to false claims settlements or recoupment for pneumonia overpayments, these DRGs are emerging targets of recovery audit contractors (RACs) and are on the CMS data reports (PEPPER and FATHOM) now being shared with hospitals and RACs, Medicare administrative contractors and fiscal intermediaries.

Pneumonia coding and documentation mishaps are still doing a number on hospital compliance, says Donna Wilson, senior director at Compliance Concepts, a Pennsylvania-based consulting firm. Simple and complex pneumonias are common diagnoses in the Medicare population. Without adequate documentation to support the clinical indicators and/or confirmation from the physician, the type of pneumonia may be miscoded.

On April 16, 2010, Connolly Consulting, the RAC for Region C (15 southern and southwestern states), added a trio of pneumonia DRGs, with and without complications/comorbidities (CC) and major CCs, to its list of audit targets:

- **MS-DRG 179** (respiratory infections and inflammations without CC/MCC),
- **MS-DRG 178** (respiratory infections and inflammations with CC), and
- **MS-DRG 177** (respiratory infections and inflammations with MCC).

All these complex pneumonia DRGs are grouped from a variety of specified types of ICD-9 diagnosis codes, Wilson says.

Simple pneumonia and respiratory infections are targets of PEPPER (the Program for Evaluating Payment Patterns Electronic Report). A product of CMS, PEPPER is electronic reports on hospital billing for 11 Medicare risk areas, which the agency provides to hospitals for use in compliance monitoring. The data program is run by a CMS contractor, TMF Health Quality Institute, the Medicare quality improvement organization in Texas. Now PEPPER and its data parent, FATHOM (First-look Analysis Tool for Hospital Outlier Monitoring), are being provided to MACs and RACs.

Three Main Causes of Errors

Wilson explains three of the prime causes of pneumonia MS-DRG errors:

1. **Incorrectly coding the type of pneumonia.** The final diagnosis is documented as gram positive pneumonia. Coders may think that gram positive translates to specified bacterial pneumonia (ICD-9-CM diagnosis code 482.89), which groups into MS-DRGs 177, 178 or 179. But the correct code assignment for gram-positive pneumonia is unspecified bacterial pneumonia, ICD-9-CM diagnosis code 482.9, which groups to the lower-paying MS-DRGs: 193 (simple pneumonia and pleurisy with MCC), 194 (simple pneumonia and pleurisy with CC) and 195 (simple pneumonia and pleurisy without CC/MCC), Wilson explains.
(2) Inappropriately coding aspiration pneumonia. Even though certain patients may appear susceptible to aspirating given their clinical features — picture an elderly nursing home resident with a percutaneous feeding tube (PEG), increasing cough, fever, and a patchy infiltrate — aspiration pneumonia can’t be coded without physician documentation, Wilson says. Coders and/or clinical documentation specialists should review the entire medical record to determine if a physician query is necessary. For example, a patient may have been seen by a speech-language pathologist, who documents within the progress notes that “patient is at risk for aspiration.” However, without the physician expressly documenting the patient has an aspiration-pneumonia diagnosis, the coder can’t assign the diagnosis code and the hospital can’t bill for the higher-paying complex pneumonia MS-DRGs. “If you code aspiration pneumonia based solely on clinical features, you may fall into the 177-to-179 MS-DRGs inappropriately when it should have been coded to a simple pneumonia,” Wilson says. If the physician has already identified pneumonia as a diagnosis, ask him or her to specify the type of pneumonia, she says.

Sequencing Trips Up Hospitals

(3) Errors around diagnosis sequencing. When patients suffer from two pneumonia-related conditions, and either one could be the principal diagnosis, things get dicey, Wilson notes. The principal diagnosis — which is defined as the “reason for admission after study” — drives DRG assignment. But sometimes two diagnoses qualify for principal-diagnosis status and the physician and coder have to decide which is dominant. “When you have a person with acute respiratory failure and aspiration pneumonia, and both of these conditions are equally treated, either one can be the principal diagnosis,” she says.

The RAC will review the DRG assignment from a sequencing perspective: which diagnosis was the principal diagnosis and which was the secondary diagnosis and did the hospital make the right decision? According to Coding Clinic, the newsletter published by the American Hospital Assn., the principal diagnosis selection should be based on “the circumstances of admission, the diagnostic workup and/or the therapy provided” (see the 2008 issue, first quarter). Once again, the best practice is to query the physician, Wilson says.

Wilson offers the following tips, based on the second quarter 1998 edition of Coding Clinic:

◆ **Remember that not all pneumonias are bacterial** and therefore won’t necessarily be complex.
◆ **Don’t assign an organism** based on lab results (e.g., gram-negative organisms in the sputum).
◆ **Don’t assign bacterial or aspiration pneumonia** relying just on clinical indications/features (e.g., increasing cough, fever, patchy infiltrate, presentation of nursing home patient with a PEG tube).

More Medicare Claims Denials Expected Under CMS’s New Medical Review Policy

In a new policy, CMS is cracking down on the way medical reviewers determine the medical necessity of services. The agency’s hired guns — recovery audit contractors (RACs), Medicare administrative contractors (MACs) and others — must stick to the documentation in their hands when performing complex medical reviews, according to the new Medicare transmittal
on clinical review judgment (338). “Clinical review judgment does not replace poor or inadequate medical records,” states the transmittal, which was unveiled May 17, 2010.

This means Medicare claims probably will be denied when a provider’s documentation is insufficient because medical reviewers can’t use “clinical inference” to deduce the medical necessity of a service by connecting the dots, says Washington, D.C., attorney Howard Young. “CMS is taking away the ability of all of their contractors to use clinical judgment in pre- and post-payment complex medical reviews, and is directing that they have to strictly and literally rely on the medical records,” says Young, with Morgan Lewis & Bockius.

There’s no more leeway for nurse and physician reviewers who think it’s obvious why providers ordered an ancillary test or performed another medical service and who may agree with the decision and therefore don’t deny the claim because of imperfect documentation, Young contends.

Medical reviewers, who are nurses and other clinicians, perform complex medical reviews to determine whether services billed to Medicare meet medical necessity or coverage criteria. Because they are medical professionals, medical reviewers use their clinical judgment to fill in the missing colors in the paint-by-numbers of a medical record if the overall picture seems to explain the reason for a service or admission.

The policy articulated in the transmittal, which will become part of the Medicare program-integrity manual, marks the end of an era. Historically, when there have been technical deficiencies, medical reviewers would typically declare that the substance of local coverage decisions (LCDs), national coverage determinations (NCDs) or regulations have been met, notes Phoenix consultant Kevin Cornish, a managing director at Navigant Consulting. “The whole issue of clinical inference and medical decision making is a fairly common part of reviews by contractors,” he notes. “But the transmittal is suggesting that even though you may have a clinical picture that warrants medical necessity for the item or service or an admission, if the medical records are deemed inadequate, then the true medical picture is irrelevant. The medical reviewer can only evaluate the documentation for its technical completeness.”

**CMS Puts Onus on Contractors**

The transmittal also requires medical reviewers to create a “longitudinal clinical picture of the patient” through the “synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes).” The term “longitudinal clinical picture” isn’t defined in the transmittal, but CMS and OIG have used the term recently in discussions with providers and consultants, Cornish says. Based on his personal experience with CMS and OIG, Cornish believes the term longitudinal clinical picture means “CMS is placing an affirmative obligation on federal contractors and their medical reviewers to consider the gathering of all relevant medical records from the provider that submitted the claim and potentially from other sites of care” related to the patient encounter under scrutiny, such as an ordering physician. What the Medicare watchdogs apparently have in mind, he says, is forcing reviewers to corroborate a billing provider’s otherwise limited medical records with information from all available sources and therefore eliminate the application of clinical inference. A net result: Contractors will have more information to delay or deny claims, he notes.

The longitudinal clinical picture language is somewhat confusing, Cornish says. It appears to set up a two-stage test. Medical records can’t be poor or inadequate, CMS says. If they are,
medical reviewers can use the longitudinal picture — not clinical inference — to figure out whether medical necessity exists. “It has the potential to bring in new data sources that were not used before because medical reviewers relied primarily on whatever the provider submitted,” he says. But now medical reviewers should rely on documentation sources from outside the provider who is billing for the services in the quest to determine whether the services were medically necessary, Cornish says. “It puts a bit of an onus on contractors to gather a broader array of documentation than they normally get from providers and will lead to more decision points and potential inconsistencies when making coverage decisions,” he says. “It will probably lead to more denials.” Providers also will have to be more sensitive to documentation generated by other providers and perhaps evaluate how much they should preemptively gather documentation themselves.

For example, the NCD on implantable cardiac defibrillators (20.4), which shock the heart during abnormal rhythms, lists the only conditions that trigger Medicare coverage. One condition is coronary artery disease with a documented prior heart attack, a measured left ventricular ejection fraction not less than or equal to 35% and inducible, sustained ventricular tachyarrhythmia. If the hospital and physician submitted an ICD claim because the patient met these conditions but the medical records reflected an ejection fraction that was above 35% (though it was low), then you may have a technical issue in the reviewer’s eyes, Cornish says.

“Based on this new guidance to the federal contractors, will any amount of additional documentation outweigh a technical shortcoming? Can a reviewer use the clinical judgment that took years for them to develop and divine the ejection fraction was low enough and there was indeed an appropriate medical necessity warranting the procedure? Yes, but the transmittal suggests that clinical review judgment can’t replace poor or inadequate medical records and if hospitals don’t provide adequate support of a regulation, NCD or other rules, then it’s incumbent on the reviewer to affirmatively gather this longitudinal medical record without using clinical review judgment,” he says. It takes on greater urgency now that DOJ is investigating hospital billing for ICD implantation.

**CMS Warned New Policy Was Coming**

According to the transmittal, CMS curbs clinical review judgment at all claims processing and program-integrity contractors, including MACs, RACs, fiscal intermediaries, carriers, the comprehensive error rate testing (CERT) contractor and zone program integrity contractors, which are CMS’s fraud and abuse investigators. These players can’t afford to lose their CMS contracts, so they are expected to apply the new limits on clinical review judgment, Cornish says.

The new policy did not fall from the sky. CMS warned in 2009 that it was coming in the wake of problems with the use of clinical inference by the CERT contractor, a CMS program-integrity player. The CERT contractor, AdvanceMed of Richmond, Va., is responsible for calculating the Medicare fee-for-service error rate for all sorts of providers and suppliers. But it was taken to task over its underestimation of the 2009 Medicare fee-for-service error rate, which was attributed in part to an overreliance on clinical inference. CMS hired SafeGuard Services, another program-integrity contractor, to independently review a sample of the same 2008 Medicare Parts A and B claims reviewed by AdvanceMed. SafeGuard Services found more errors in the same samples, and the HHS Office of Inspector General did an audit to find out why. In its September 2009 report (A-01-09-00511), OIG noted that for some claims, the
CERT contractor and SafeGuard Services “differed in professional judgment as to how they interpreted the medical documentation and how much documentation was required to determine medical necessity.” For other claims, the CERT contractor relied on medical records and beneficiary claim histories instead of physician orders as required by Medicare to prove the physician intended to order the tests.

**CMS Manual Was ‘Vague’ on Subject**

In a letter responding to OIG’s findings, then-acting CMS administrator Charlene Frizzera acknowledged that the CMS program integrity manual “is vague regarding how much clinical judgment contractors can use when reviewing this documentation. As a result, the CERT contractor relied more heavily on clinical judgment than other contractors when making payment determinations in accordance with one section of our manuals (PIM, Chapter 3, §3.4.5, Section C).” After an internal review, CMS decided to revise its manuals to “clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors and to reconcile any apparent conflicts between different sections of the manuals,” Frizzera stated. CMS also told the CERT contractor to chill out in its use of clinical review judgment.

Less than a year later the transmittal was issued, and it will have “a significant ripple effect,” says Young, a former senior OIG attorney. More claims will be denied on account of imprecise medical record documentation and more denials will be appealed. “Obviously there is an incentive to appeal if you believe the service is medically necessary.” Providers stand a good chance of winning these appeals because administrative law judges (ALJs) aren’t bound by CMS’s muzzling of clinical inference, Young says.

**ALJs Can Look at Bigger Picture**

ALJs, who are high-level appellate judges in the HHS administrative system, are free to consider the big picture. That includes the fact that Medicare for many years allowed its contractors to use clinical inference in connection with medical reviews, which suggests it isn’t inherently inappropriate, he says. “They just changed the standard,” Young notes.

Given the new world order introduced by the transmittal, which was set to take effect June 15, 2010, Young urges providers to improve documentation and train clinicians. Let them know about the restrictions on clinical inference by medical reviewers during complex reviews. “Explain that medical reviewers are not at liberty to [assume anything] that’s not in the medical records even though it may be clinically obvious,” he says. ❖

**RAC Auditors Target MS-DRGs With One Complication; Discussion Period May Help**

Beware the potential vulnerability of MS-DRGs with one complication/comorbidity (CC), which are a seductive target for Medicare program-integrity auditors. If the lone CC or major CC (MCC) can be knocked out, payment drops to the plain-vanilla MS-DRG rate.

Recovery audit contractors (RACs) and “RAC-like” auditors for Medicare Advantage plans are using other tactics as well to downcode MS-DRGs. But when their denials are unfounded, auditors may be willing to listen to reason. For example, one hospital has had success with
the RACs’ “discussion period,” which is a pre-appeal opportunity to prove that a denial is mistaken.

In light of these new approaches by auditors, “we conduct a second review of selected Medicare traditional discharges before billing to make sure we can support the CCs and MCCs that are coded on the chart,” says Carol Osborn, Ph.D., associate director of coding and compliance for Ohio State University Medical Center.

MS-DRGs are selected according to the principal diagnosis, which is the condition established after study to be mainly responsible for causing the admission. Everything that’s not the principal diagnosis is a secondary diagnosis. Some secondary diagnoses are CCs and MCCs, which increase MS-DRG reimbursement, and some are not, says Nelly Leon-Chisen, director of coding and classification at the American Hospital Assn. and executive editor of Coding Clinic, AHA’s coding newsletter.

According to the ICD-9-CM Official Guidelines for Coding and Reporting, to be codable, a secondary diagnosis must require:

- **Clinical evaluation by the physician;**
- **Therapeutic treatment;**
- **Diagnostic procedures;**
- **Extended hospital stay;** or
- **Increased nursing care and/or monitoring.**

Many patients have multiple secondary diagnoses that may qualify as CCs or MCCs. So RAC and RAC-like auditors are setting their sights on cases with just one CC or MCC code assignment, Osborn says. If the only CC or MCC can be eliminated, auditors change the MS-DRG to the lower-paying version.

“If there are two to three CCs, it’s harder to change the MS-DRG. But with one CC, it is easier to question the documentation that supports the code assignment, which is low-hanging fruit for the auditors,” Osborn says. “They probably win a lot of the time because hospitals may lack the resources to appeal” when their claims are correct. In other cases, the documentation does not support that the secondary diagnosis was evaluated or treated during the hospitalization and therefore the claims were incorrect.

For example, auditors may target cardiac arrhythmia and conduction disorders, Osborn says. That’s MS-DRG 310 or 309 with CCs and 308 with MCCs. “A lot of these patients come in and have very short stays,” she says. They have comorbid conditions, such as acute coronary syndrome, listed in the history, but the conditions aren’t treated. “If they’re not evaluated and/or treated, they don’t qualify as a CC so the auditors focus on that,” she says.

Hospitals need to strengthen the understanding that coders have of what it takes to meet the definition of a “secondary diagnosis.” But they also need to be on guard for auditor mistakes. Osborn says that auditors recently eliminated a comorbid condition for a patient with a congenital heart problem because the anesthesiologist — not the attending physician — determined the condition presented too high a risk for surgery. The anesthesiologist documented it as part of the ASA risk score (the American Society for Anesthesiologists’ assessment of surgery risk). “He used that condition in calculating the ASA score so the condition was evaluated — one of the criteria for a reportable diagnosis,” Osborn notes.
Auditors Can Be Dead Wrong

The auditors rejected the claim for the MS-DRG with MCC on the grounds that anesthesia notes can’t be used to support CCs and MCCs. But the auditors were dead wrong. Coding Clinic explicitly allows use of anesthesia notes in this context. “Code assignment may be based on other physician (i.e., consultants, residents, anesthesiologist, etc.) documentation as long as there is no conflicting information from the attending physician. Medical record documentation from any physician involved in the care and treatment of the patient, including documentation by consulting physicians, is appropriate for the basis of code assignment,” according to Coding Clinic (First Quarter 2004, April 20, 2004, pp. 18-19).

After Osborn provided the Coding Clinic citation to the RAC-like auditors, they agreed with the original MS-DRG assignment.

CCs are not the only focus of RACs and RAC-like auditors, who are targeting many kinds of MS-DRGs for all different reasons. Sometimes claims denials for these MS-DRGs are baseless and the hospital has to prove them wrong, hopefully before an expensive appeals process.

For example, Osborn says some of the hospital’s claims for HIV infection were denied because they reported the ICD-9 diagnosis code for symptomatic HIV (042). Auditors down-coded the claim to the diagnosis code for asymptomatic HIV (V08), which groups to a much lower paying MS-DRG. But the auditors were incorrect, she says. Once HIV patients have been diagnosed with symptomatic HIV, that’s their status forever — even if antiviral medications make them seem well or they’re admitted for a reason unrelated to HIV, Leon-Chisen says.

“Patients with any known prior diagnosis of an HIV-related illness should be coded to 042,” according to the Official Guidelines for Coding and Reporting. “Once a patient has developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.” It was a burden for the hospital to prove the patients had already crossed the threshold into symptomatic HIV and therefore would always be coded as 042, because it wasn’t the reason for the recent hospitalization. “We have to send [auditors] all past medical records to prove the patient had ‘full-blown’ AIDS to support our assignment of 042,” Osborn says.

The hospital also disagreed with the RAC when it challenged a physician’s diagnosis of aspiration pneumonia, Osborn says. The RAC implied the hospital couldn’t code for aspiration pneumonia because the physician didn’t order a swallow study to confirm the patient’s diagnosis. So the RAC changed the diagnosis and MS-DRG to simple pneumonia. This was troubling on several levels, Osborn says. First, no rule exists requiring a swallow study to code aspiration pneumonia. Second, coders don’t assign codes from diagnostic test results; they code from documentation of physician diagnoses.

So Osborn took advantage of the RAC’s discussion period, which is the time to work through unfair claims denials before going the appeals route. Hospitals don’t want to waste time and money on iffy appeals, and RACs presumably feel the same way because if they lose, they get no contingency fee.

As it turned out, pneumonia was the wrong diagnosis, Osborn says. The patient actually was in respiratory distress from fluid overload due to missed dialysis. The hospital and RAC
hammered it out together. In this instance, “the RAC discussion period worked,” she says. “It was a positive experience.”

**OR Procedures Are RAC Targets**

Another RAC target is the family of MS-DRGs, with CC or MCC, around extensive operating room (OR) procedures unrelated to the principal diagnosis and nonextensive OR procedures unrelated to the principal diagnosis. For example, a herniorrhaphy was performed on a patient found to have an incisional hernia after admission for acute renal failure. The case grouped to MS-DRG 988 (non-extensive OR procedure unrelated to principal diagnosis) rather than a renal failure MS-DRG. Even though this is an accurate depiction of the patient’s hospitalization, the RAC would scrutinize the supporting documentation for the MS-DRG because it’s not likely a patient admitted for renal failure would have a hernia repair, Osborn says.

Given the parade of MS-DRGs under RAC and RAC-like scrutiny, her hospital “assumes everything is a target,” Osborn says. To reduce errors, Osborn’s department audits selected MS-DRGs. They are chosen based on denials, RAC targets and recommendations from an external auditor. One realization from the investment in an external compliance audit: “We have a 98% coding accuracy rate” in terms of diagnosis code assignments, but coders often have trouble selecting the principal diagnosis, she says. Sometimes coders pick the chief complaint as the principal diagnosis and that’s not always the case. As a result, the hospital may bill Medicare for the wrong MS-DRG, which could translate into less or more reimbursement, depending on the circumstances. In response, the hospital bought an audio-seminar on selecting the principal diagnosis and will monitor to ensure that coders improve in this area.

**CMS RAC Chief: Medical-Necessity Audits Are Coming, Will Be ‘Big Mountain to Climb’**

Medical-necessity reviews by recovery audit contractors (RACs) are expected to pick up steam this summer, CMS’s top RAC official told AIS in June 2010.

So far, RACs have sent 15 to 20 hospitals about 140 additional documentation requests (ADRs) involving medical-necessity issues, says Connie Leonard, director of the Division of Recovery Audit Operations. The documentation was requested for the RACs’ probe audits, which are mini-reviews conducted to flush out high-risk areas that merit a full-scale audit. After finishing the probe audits, the RACs submitted only four or five issues to the CMS new issues review board, which must sanction audits before RACs begin work. But Leonard says “we expect that will change as we get further into the summer [of 2010].”

As RACs move into “more subjective areas” — meaning audits of site of service and medical necessity of services provided — Leonard encourages providers to “stay on top of what the RACs are doing.” That means monitoring RAC web portals, which contain detailed claims information, ADRs, audit results and demand letters. “I always encourage providers to do their own quality reviews,” she says. “If they pay attention to their own compliance shops, I don’t think the RAC program will be a big deal for them. Yes, it’s an inconvenience for them, but if RACs request medical records and don’t find problems, they will eventually stop requesting medical records [from that provider]. It’s not cost-effective for RACs to review hospitals where they don’t find improper payments.”
Medical necessity will be “the big mountain to climb,” Leonard says. “You start with other types of reviews and slowly get to medical necessity.” During medical-necessity audits, RAC medical directors will be available to discuss particular cases with physicians and hospital medical officers. CMS also is preparing a new MedLearn Matters article to help providers improve documentation of medical necessity and compliance with admission orders and other requirements. Leonard hoped it would be out by late September 2010.

One of the most threatening aspects of medical-necessity audits for hospitals involves RAC determinations that admissions were unwarranted. When that happens, CMS has said hospitals can rebill only for Part B ancillary services provided to these patients rather than an APC under the outpatient prospective payment system. Leonard says she agrees the policy is unfair to hospitals but that CMS’s hands are tied by statute. “CMS has been working on that issue with the American Hospital Assn.,” Leonard says. “We support AHA and providers.” She says CMS policy officials and legal counsel have told her that Congress will have to make changes to the law before outpatient rebilling is permitted. “We have been told this cannot be just a manual or regulatory change.”

Meanwhile, RACs are focusing intensely on MS-DRG validations and durable medical equipment (DME) billing. Many MS-DRGs have made the RAC target lists. But Marie Casey, deputy director of CMS’s Division of Recovery Audit Operations, tells AIS that “one area we always have a problem with is the respiratory failure diagnosis.” She says hospitals often miscode respiratory failure or have sequencing problems in this area (e.g., involving pneumonia and chronic obstructive pulmonary disease). “But we haven’t seen huge dollars yet in that area,” Casey says.

In fact, the top overpayment finding from the RACs so far involves DME, Casey says. RACs are finding various errors, such as DME billed for beneficiaries after their date of death and DME billed for beneficiaries while they are inpatients.

**RACs Challenge ‘Debatable Diagnoses’**

Leonard and Casey won’t be involved with the Medicaid RACs ordered by the health reform law, other than sharing lessons learned. Each state Medicaid agency is required to contract with a RAC to hunt for Medicaid overpayments. “CMS is providing general oversight,” Leonard says. Plans for the Medicare Parts C and D RACs also mandated by the reform law are still being discussed internally, she says.

It makes sense for respiratory failure to be a high-error MS-DRG, says Drew Rothschild, M.D., with Navigant Consulting. “There are many differences of opinion about what the diagnosis means and how it needs to be documented,” he says. For example, sometimes patients can’t breathe, but physicians don’t write respiratory failure; they call it “only” an asthma attack or respiratory insufficiency, even in severe cases where patients haven’t resumed breathing on their own, sometimes after intubation, he says. “Many physicians base the diagnosis only on ABG [arterial blood gas] results. But ABGs aren’t performed nearly as often as they were in the past, so they frequently aren’t available,” Rothschild says. “Other physicians require acidosis, ignoring the many other causes of respiratory failure, such as hypoxic acute respiratory failure.” Some physicians focus primarily on specific lab values or pulmonary lung testing, particularly in chronic failure. The bottom line: “There is no consistency in what people think is necessary,” he says. And Rothschild has seen some doctors overdiagnose respiratory failure, so he recommends that coders query physicians if anything seems iffy.
Hospitals will run into a problem with respiratory failure because RACs seize on debatable documentation of diagnoses, Rothschild says. “RACs don’t want [providers] to just state the diagnosis. If it seems debatable, you have to explain why you believe it’s true. You have to make it so it’s not debatable in any way,” Rothschild says.

Though the RACs list many MS-DRGs on their websites, which means they have been approved for audit by CMS, hospitals say the audits tend to focus on a handful at a time — although the requests for medical records can be extensive. For example, in January 2010, Franciscan Health System in Washington state received 14 documentation requests targeting nine MS-DRGs from its RAC, Health Data Insights, says Jonathan Eastabrooks, the audit contractor program liaison for Franciscan. The MS-DRGs are simple pneumonia and pleurisy; respiratory system diagnosis with ventilator support 96+ hours; other circulatory system diagnoses; extensive operating room (OR) procedure unrelated to principal diagnosis; respiratory infections and inflammations; other OR procedures for injuries; and septicemia without mechanical ventilation 96+ hours.

In March 2010, the RAC requested medical records for 205 MS-DRGs, with 40% of them focused on three DRGs: other circulatory system diagnoses, septicemia and extensive OR procedures unrelated to principal diagnosis.

Eastabrooks notes that 73% of the MS-DRGs audited had only one CC or MCC. For example, RAC auditors said they couldn’t find a secondary diagnosis of acute hemorrhagic anemia to justify the CC, so they downcoded the MS-DRG from other OR procedures for injuries with CC to other OR procedures with no CC/MCC (from 908 to 909). That reflects a trend of RACs and other auditors zeroing in on MS-DRGs with a single complication they can potentially dismiss, which would downcode the MS-DRG to the lower-paying version with no CC or MCC.

**RAC Teams Should Be Diverse**

Franciscan has a large RAC team responding to audits and preparing appeals. Members of the RAC team come from many departments, including the business office, care management, health information management and compliance. The involvement of a lot of people helps Franciscan’s five hospitals fend off unfair RAC denials, which it did by successfully using the RAC discussion period. Recently, the RAC denied a claim for physical therapy services (CPT 97001), saying the hospital exceeded the number of units allowed per patient per day. The patient was referred twice for PT, but the referrals were from two different doctors for two separate disorders. “They don’t like to schedule them on the same day, but they did,” Eastabrooks says. “We had to show the RAC we didn’t screw up. We engaged them in discussion and it was successful.”

CMS created the discussion period for providers to present evidence to RACs before filing formal appeals, to persuade them that claims denials were unwarranted. Eastabrooks says Franciscan prepares appeals letters for denials but tries to resolve disputed claims denials through the discussion period.
RAC Bases Its Medical-Necessity Audit on Another Hospital’s False Claims Case

In its first round of hospital medical-necessity reviews, a recovery audit contractor (RAC) is targeting inpatient admissions for diseases and disorders of the nervous system, according to a letter received by a Colorado hospital in summer 2010. The RAC says it chose this target—nonspecific cerebrovascular accident and precerebral occlusion without infarction without major complications and comorbidities (MCC) (MS-DRG 068)—because of another hospital’s false claims settlement for “unreasonable and unnecessary hospital admissions.” That rationale has raised some eyebrows because it is unusual for a hospital to face a RAC audit as a result of an unrelated hospital’s liability; also, RACs have typically relied on different sources to identify risk areas (e.g., data mining, HHS Office of Inspector General reports).

The RAC, Connolly Healthcare, which audits providers and suppliers in Region C (Ala., Ark., Colo., Ga., La., Miss., N.C., S.C., N.M., Okla., Tenn., Texas, Va., W.Va., Puerto Rico and the Virgin Islands) asks the hospital for additional documentation as part of a “test claim sample.” This means it is still conducting a probe audit, which is a mini-review designed to determine whether a risk area warrants a full-scale audit subject to approval by CMS’s new issues review board. “No improper payments may be recovered until CMS has approved the complex review audit concept,” the RAC reiterates in the letter.

But the letter provides compliance officers with a window into medical-necessity reviews that are getting under way. “This is the warning sign that large-scale RAC [medical-necessity] reviews are here,” says Michael Taylor, M.D., senior medical director for government appeals and regulatory affairs at Executive Health Resources (HER) in Philadelphia.

Under the rationale for the review cited in the letter, the RAC says that “good cause is evidenced by data analysis that identifies errors or patterns of overutilization on the part of a provider or supplier.” More specifically, the RAC letter informs the hospital that it had “good cause” for reopening claim(s) for nonspecific cerebrovascular accident and precerebral occlusion without infarction without MCC because of an $846,461 settlement resolving allegations “that one facility knowingly made false claims to Medicare for unreasonable and unnecessary hospital admissions.” Though the RAC doesn’t name the unrelated facility that settled the case, Wheaton Community Hospital in Minnesota and physician Stanley Gallagher in January 2010 agreed to pay $846,461 to settle false claims allegations over unreasonable and unnecessary hospital admissions, according to the Department of Justice.

RAC Has a ‘Strange Notion’

The RAC’s reasoning for the audit of the Colorado hospital was met with surprise. “What a strange notion that the cause for auditing someone is found in the fact that someone else had a problem with the issue,” says Minneapolis attorney David Glaser, with Fredrikson & Byron. “Someone else’s settlement doesn’t create good cause for an organization. That is one of the craziest things I ever read.” It’s tantamount to saying that finding illegal drugs on one person gives the police probable cause to suspect everyone else of having illegal drugs, he says.

Taylor says that Connolly Healthcare also is eyeing diseases and disorders of the circulatory system at some hospitals based on a false claims investigation of unrelated facilities.
“This blurs the lines between errors and fraud,” Taylor says. “It’s important for providers to be aware there is increasing emphasis on overpayments and fraud and abuse. All are fair game and providers should self-audit if they feel vulnerable.”

In terms of the specific DRG targeted in this medical-necessity review, Taylor says that some patients with less serious symptoms, such as lightheadedness, may be mistakenly coded as transient ischemic attacks (TIAs), a kind of stroke that is assigned to MS-DRG 068. And patients with low-risk TIAs may be conducive to outpatient treatment (i.e., observation). But a serious TIA generally requires inpatient care, he says. “Many infarcts and high-risk TIAs are justified as admissions,” Taylor says. HER has successfully appealed Medicare denials for TIA admissions. He says these cases require physician review. “They are not cut and dried. They require complex medical thought,” Taylor notes.

In the letter, the RAC asks the hospital to provide the medical-records requests (and will be reimbursed by the RAC for the cost of copying the documentation), and the RAC will relay the results of its review to the hospital. The requests for medical records are extensive. They include the face sheet; discharge summary; history and physical; emergency room records; nursing notes; consults; physician orders and progress notes; lab, radiology, operative and pathology reports; ICD-9 codes submitted; physician queries; and medication administration records.

**Admission Decisions Are Hit With Double-Whammy of RAC Scrutiny and MAC Attacks**

Recovery audit contractors (RACs) are starting to scrutinize medical necessity decisions for certain DRGs, such as chest pain, atherosclerosis and gastrointestinal disorders, but hospitals have just as much to fear from Medicare administrative contractors. MACs also are reviewing admission determinations, and have the authority to withhold payment until claims are reviewed if they believe a hospital exhibits a pattern of shunning observation in favor of more lucrative inpatient beds. This means hospitals can get clobbered coming and going in terms of medical necessity, from MAC attacks on the front end to RACs on the back end.

Tensions are rising in the medical necessity arena now that CGI Federal, the RAC for Region B, in mid-August 2010 posted 18 DRGs that it will audit for site-of-service accuracy. The DRGs are all over the map, and include bread-and-butter issues for Medicare auditors, such as chest pain, back pain (musculoskeletal disorders), syncope, kidney and urinary tract infections, heart failure and shock, nutritional and metabolic disorders and chronic obstructive pulmonary disease.

But others are unanticipated, such as red blood cell disorders, says Michael Taylor, M.D., senior medical director of government appeals and regulatory affairs for Executive Health Resources in Philadelphia. RACs tend to focus on high-dollar admissions that end up being short stays, especially when there are “ambiguities in admission criteria,” he says. “These are good areas for the RAC to mine for payment errors.”

At the same time, MACs, including Trailblazer Health Enterprises, Noridian Administrative Services and WPS Medicare, are scrutinizing admissions for DRGs such as chest pain and cardiac stents, Taylor notes. Interestingly, both RACs and MACs are auditing the site of
service for stent surgery. MACs over the past year have been focusing on drug-eluting stents (DRG 247), “which comprise the majority of stents,” Taylor says. But CGI will audit the far less popular version, nondrug-eluting stents (DRG 249), he says. “It’s very interesting to see there has been a differentiation in the role of contractors,” he says. “I think we have to watch closely to see if RACs will be approved for the same subjects as the MACs or if CMS has a plan in mind to give them differing areas of concentration.”

With MAC and RAC pressure coming to bear on medical necessity in certain DRGs, hospitals can focus their documentation and admission criteria improvement efforts in certain areas. With some DRGs more than others, admission turns on a documentation dime. For example, both chest pain (MS-DRG 313) and syncope and collapse (MS-DRG 312) — high-volume Medicare diagnoses — “can describe patients who are either at grave risk or who could be treated with observation or even discharged and [referred] for follow-up care,” depending on the specifics of a number of factors documented by the physician, Taylor says. “Those are issues where documentation is absolutely critical.”

**Admissions Depend on Many Factors**

Taylor emphasizes that physicians must consider admissions in light of the criteria spelled out in the Medicare Benefit Policy Manual. It explains that admissions hinge on the severity of signs and symptoms, the need for diagnostic evaluation, the length of time the patient is expected to require hospitalization, and the risk of adverse outcomes, among other things. “If physicians are clearly documenting the severity and amount of risk, that will support an appropriate admission much more strongly,” he notes.

Physicians drop the documentation ball most frequently when it comes to explaining their worries about the patient, Taylor says. “The physician’s concern about adverse events is often the determining factor of whether these patients need hospitalization or could be treated in an outpatient setting,” he explains. “If the physician feels admission is necessary because the patient has a life-threatening condition, the physician needs to document exactly what that condition is, exactly what the physician’s concern is, and what could happen to that patient if he or she is not treated at the appropriate level of care.” The risk of adverse events is impacted by the patient’s age, comorbidities (e.g., diabetes, hypertension, heart disease), and underlying illnesses or diseases (e.g., arrhythmias), among other things.

Chest pain, for example, is characterized by specific factors that physicians should document to paint a picture of the outpatient versus inpatient decision-making process. Among them: the level of the patient’s troponin (three proteins integral to cardiac muscle contractions); EKG findings; past medical history and comorbidities (e.g., history of heart disease); nature and description of chest pain (e.g., similarity to previous heart attack); and vital signs (e.g., whether blood pressure is elevated or depressed; whether heart rhythm is normal or abnormal).

For its part, syncope can be caused by a broad range of underlying illnesses and diseases, Taylor says. “Physicians should spell out specifically which disease is the concern and which is being investigated,” he says. “If the condition that is being investigated is potentially a cardiac arrhythmia — a disturbance in heart rhythm that could result in sudden death — that’s a much more serious condition than a minor fainting spell in an otherwise healthy patient.”

Hospitals are experimenting with strategies for reducing site-of-service errors. For example, WellSpan Health in York, Pa., is now employing a full-time physician adviser in the
case management department who performs concurrent reviews of admission and observation decisions, says Ann Kunkel, director of case management. “Our physicians used to look at cases retrospectively, but we changed the physician advisor role to do clinical rounds with our case management staff,” she says. “We found our clinicians need the support of the physicians in real time.” The physician adviser focuses on gray-area admissions, such as chest pain, dehydration and syncope, and evaluates observation cases because sometimes physicians put patients who warrant admission into observation because they fear the scrutiny of RACs and MACs. The physician advisor reviews cases and either supports the level of care ordered by the attending physician in consultation with case management, or suggests a different setting (inpatient admission versus observation).

Kunkel says attending physicians “take the physician adviser’s recommendation under advisement and often follow it.” Other medical-necessity issues tackled by the physician adviser are social admissions and recalcitrant patients who refuse to leave the hospital (e.g., they don’t want to go to a nursing home). In these cases, the physician adviser supports the staff in arranging post-acute care. WellSpan is working toward 100% concurrent case review, though “it’s still an evolution,” she says.

In addition to reducing medical-necessity errors, WellSpan’s use of the physician advisor demonstrates compliance with the utilization review requirements of the Medicare conditions of participation. An effective utilization review process includes a method for resolving disagreements over admission decisions, Kunkel says. When a hospital disagrees with the way an attending physician handles the level of care, it must have two independent physician reviewers determine the appropriate course of action, she says. If WellSpan wants to challenge an attending physician’s site-of-service determination, its physician adviser would “start a dialogue with the attending and hopefully get [his or her] concurrence on a plan. If that didn’t work, we then bring in the UR committee’s physician” and come to an agreement one way or another.

Hospitals should be prepared for significant recoupment based on alleged lack of medical necessity. During the RAC demonstration, which began in three states but ultimately involved six, one in three claims was denied on the grounds that patients should have been treated at a less-intense site of service (e.g., observation), Taylor notes. And lack of medical necessity and the inextricably linked issue of insufficient documentation together account for 70% of inpatient Medicare fee-for-service errors, according to a recent HHS Office of Inspector General/Comprehensive Error Rate Testing analysis.

Given the importance of documenting medical necessity, hospitals should strengthen their internal processes for responding to RAC, MAC and other auditors’ requests for medical records. But this may prove trickier than anticipated.

“You could have documents not within the core medical records,” says Kevin Cornish, national director of the health care dispute compliance and investigation practice for Navigant Consulting. Many hospital departments keep separate records that would not be included in the documentation printed by the health information management department, he says, (e.g., case management, surgical folders and outlying clinics).

“The [people] fulfilling RAC documentation requests really need to be familiar with the hospital’s medical records policies and procedures to ensure that all pertinent documentation is provided,” Cornish says.
How to Make Orderly RAC Responses

Here are Cornish’s tips for an orderly RAC response process:

♦ **Ensure that a tracking and reporting system is in place** so that deadlines for submission are met.
♦ **Maintain a copy or a log of exactly what information was sent** to the RAC to assist in the appeals process.
♦ **Coordinate with compliance and/or legal any/all submissions of medical records** pursuant to a RAC request.
♦ **Critically review all documentation submitted to the RAC** to ensure that the documentation submitted answers questions of coverage, including:
   1. Beneficiary eligibility,
   2. Services were reasonable and necessary to treat medical conditions,
   3. Services provided were necessary at the level of care they were provided as opposed to some less intensive setting,
   4. Billed services were properly coded,
   5. For DRG based claims, the coding worksheet and supporting documentation are included,
   6. For skilled nursing facility/home health claims, all records that support the MDS/OASIS are included,
   7. For APC/ambulatory surgery claims, all procedure reports and physician notes are included, and
   8. For hospice claims, all required certifications and care plans are included.
♦ **Ensure the records are organized** and easy to follow.
♦ **Be vigilant when copying two-sided forms** to ensure that both sides are copied. It’s risky to send RACs and other reviewers two-sided copies because it invites scanning errors.
♦ **Provide a cover letter with a summary** of the patient and encounters/admissions as part of the initial RAC response.
♦ **Proactively review records on a sample basis** to ensure that documentation supports all coverage criteria.
♦ **Target claims for services that are subject** to national coverage determination/local coverage determination guidance.
♦ **Maintain a centralized LCD/NCD library, distribution and utilization process** to ensure that the organization is contemporaneously and fully aware of any/all applicable coverage guidelines and has integrated such information into documentation, coding, billing and medical necessity processes.
♦ **Utilize management staff and medical directors** to provide corrective actions for illegible documentation.
♦ **Provide active feedback for practitioners** using electronic medical records where standard language sets or copy and paste functions are active or where free text fields are underutilized.
Medicare Auditors Target Signature Rules After Finding ‘Significant Problems’

Medicare signature requirements are in the spotlight, with Medicare contractors warning providers that claims can be denied if medical records lack legible signatures and are not timed and dated.

Two recovery audit contractors (RACs) are already targeting noncompliance in this area, so hospitals may want to assess how well physicians conform to the signature mandate and implement compliance solutions.

Hospitals around the country have been receiving notices from their Medicare administrative contractors, fiscal intermediaries and carriers about noncompliance related to signatures. For example, in a letter earlier in 2010, Palmetto GBA, the Ohio-based carrier, said it “has seen an escalating number of errors assessed by the Comprehensive Error Rate Testing (CERT) contractor due to signature problems with practitioners’ medical records, X-ray reports and laboratory/radiology orders.” In April 2010, Palmetto suggested hospitals “take immediate action” if changes are needed. Problems with signatures, the carrier says, are widespread.

“We are watching closely to see how CMS and their auditors will enforce dating, timing, signing and legibility requirements,” says Cheryl Rice, vice president and chief corporate responsibility officer for Catholic Healthcare Partners, a Cincinnati-based nonprofit with 32 hospitals. “Providers need to ask how their facilities would fare if auditors held them to the strictest interpretation. The [auditors’] rationale could be either documentation is illegible so we can’t read it and determine if it supports services, or it’s not complete. But it depends on how strictly auditors enforce these rules.”

The rules at issue appear in the hospital Medicare conditions of participation. In a 2007 regulation, CMS revised the conditions of participation to clarify that physicians and other caregivers must sign a medical-record entry in real time — not after the fact — and mark the date and time. As Sec. 482.24 of the regulation states, “all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.”

Transmittal 327 Is Turning Point

The conditions of participation set a deadline for authenticating verbal orders, which means a physician must sign a phoned-in order in person. “If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours,” according to Sec. 482.24.

While the new requirements may seem like a no-brainer, they came as a surprise to some physicians and hospitals. Some providers mixed up the 30 days they have to complete the medical record (e.g., discharge summary, reports, history and physical) with the idea that they had 30 days to time, sign and date.

Then in March 2010, CMS issued a transmittal warning that illegible signatures could be grounds to reject claims during an audit. Medicare Transmittal 327, which revised the Medicare Program Integrity Manual, stated that Medicare auditors may disregard orders and other
DOs and DON'Ts for Medicare Signature Requirements

Palmetto GBA, the Ohio-based Medicare fiscal intermediary and carrier, developed these examples of signatures that are compliant and not compliant with Medicare requirements.

### SIGNATURE REQUIREMENTS: ACCEPTABLE EXAMPLES

<table>
<thead>
<tr>
<th>Acceptable Electronic Signature Examples</th>
<th>Acceptable Written Signatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Chart “Accepted by” with provider’s name.</td>
<td>◆ Legible full signature.</td>
</tr>
<tr>
<td>◆ “Electronically signed by” with provider’s name.</td>
<td>◆ Legible first initial and last name.</td>
</tr>
<tr>
<td>◆ “Verified by” with provider’s name.</td>
<td>◆ Illegible signature over a typed or printed name.</td>
</tr>
<tr>
<td>◆ “Reviewed by” with provider’s name.</td>
<td>◆ Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory. An example: An illegible signature appears on a prescription. The letterhead of the prescription lists three physicians’ names. One of the names is circled.</td>
</tr>
<tr>
<td>◆ “Released by” with provider’s name.</td>
<td>◆ Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: (1) a signature log, or (2) an attestation statement.</td>
</tr>
<tr>
<td>◆ “Signed by” with provider’s name.</td>
<td>◆ Initials over a typed or printed name.</td>
</tr>
<tr>
<td>◆ “Signed before import by” with provider’s name.</td>
<td>◆ Initials NOT over a typed/printed name but accompanied by: (1) a signature log, or (2) an attestation statement.</td>
</tr>
<tr>
<td>◆ “Signed: John Smith, M.D.,” with provider’s name.</td>
<td>◆ Unsigned handwritten note not where other entries on the same page in the same handwriting are signed.</td>
</tr>
<tr>
<td>◆ Digitized signature: Handwritten and scanned into the computer.</td>
<td>◆ “Signature Derived from Controlled Access Password.”</td>
</tr>
<tr>
<td>◆ “This is an electronically verified report by John Smith, M.D.”</td>
<td>◆ “Electronically signed by” with provider’s name.</td>
</tr>
<tr>
<td>◆ “Authenticated by John Smith, M.D.”</td>
<td>◆ “Authorized by: John Smith, M.D.”</td>
</tr>
<tr>
<td>◆ “Authorized by: John Smith, M.D.”</td>
<td>◆ “Digital signature: John Smith, M.D.”</td>
</tr>
<tr>
<td>◆ “Confirmed by” with provider’s name.</td>
<td>◆ “Confirmed by” with provider’s name.</td>
</tr>
<tr>
<td>◆ “Closed by” with provider’s name.</td>
<td>◆ “Finalized by” with provider’s name.</td>
</tr>
<tr>
<td>◆ “Finalized by” with provider’s name.</td>
<td>◆ “Electronic approval by” with provider’s name.</td>
</tr>
<tr>
<td>◆ “Electronically approved by” with provider’s name.</td>
<td>◆ “Signature Derived from Controlled Access Password.”</td>
</tr>
</tbody>
</table>

**Special Notes for Electronic Signatures:**

- **Electronic signatures** usually contain date and timestamps and include printed statements, e.g., “electronically signed by,” or “verified/reviewed by,” followed by the practitioner’s name and preferably a professional designation. Note: The responsibility and authorship related to the signature should be clearly defined in the record.
- **Digital signatures** are an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage.

Note: Be aware that electronic and digital signatures are not the same as “auto-authentication” or “auto-signature” systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been “Signed but not Read” are not acceptable.

### SIGNATURE REQUIREMENTS: UNACCEPTABLE EXAMPLES

<table>
<thead>
<tr>
<th>Unacceptable Signatures*</th>
<th>Unacceptable Signature Examples*</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Signature “stamps” alone in medical records are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.</td>
<td>◆ “Signing physician” when provider’s name is typed. Example: Signing physician: John Smith, M.D.</td>
</tr>
<tr>
<td>◆ Reports or any records that are dictated and/or transcribed, but do not include valid signatures “finalizing and approving” the documents are not acceptable for reimbursement purposes. Corresponding claims for these services will be denied.</td>
<td>◆ “Confirmed by” when a provider’s name is typed. Example: Confirmed by: John Smith, M.D.</td>
</tr>
<tr>
<td>◆ Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is unaccompanied by: (1) a signature log, or (2) an attestation statement.</td>
<td>◆ “Signed by” followed by provider’s name typed and the signing line above, but done as part of the transcription.</td>
</tr>
<tr>
<td>◆ Initials NOT over a typed/printed name unaccompanied by: (1) a signature log, or (2) an attestation statement.</td>
<td>◆ “This document has been electronically signed in the surgery department” with no provider name.</td>
</tr>
<tr>
<td>◆ Unsigned typed note with provider’s typed name.</td>
<td>◆ “Dictated by” when provider’s name is typed. Example: Ddictated by: John Smith, M.D.</td>
</tr>
<tr>
<td>◆ Unsigned typed note without provider’s typed name.</td>
<td>◆ Signature stamp.</td>
</tr>
<tr>
<td>◆ Unsigned handwritten note, the only entry on the page.</td>
<td>◆ “Signature on file.”</td>
</tr>
<tr>
<td>◆ “Filled by.”</td>
<td>◆ “Electronically signed by agent of provider.”</td>
</tr>
</tbody>
</table>

*For the sections listed above with an asterisk, Palmetto GBA will contact the person or organization that submitted the claim(s) and ask him/her to submit an attestation statement (for missing signatures) or a signature log (for illegible signatures). The contact may occur via phone or written request. The attestation statement must be received within 20 calendar days of the call or the date the written request is received by the post office. In order to be considered valid for Medicare Medical Review purposes, your attestation statement must include the following elements:

- the printed full name of the physician/practitioner,
- sufficient information to identify the beneficiary,
- date of service, and
- signature and date by the author of the medical record entry.
documentation if signatures are missing or illegible, although auditors will consider physician attestations or signature logs as an alternate form of identification.

Now two RACs, Connolly Healthcare and CGI Federal, are targeting “inpatient admissions without a physician’s inpatient admit order.” The reason this appears to be partly a signature review, Rice says, is that the RACs cite the sign/date/time/authenticate section of the conditions of participation as one basis for the review.

**Improving Compliance With Signature Rules**

Warnings about signature noncompliance have even made their way onto remittance advices, which is a twist. National Government Services (NGS), an FI and carrier for 10 states, has been using remittance advices to inform some providers to submit key documentation for review before the contractor will fork over payment. The remittance advices state that NGS will deny or ignore documentation in determining coverage or payment if it’s missing the supporting signature, date or time, or the physician’s attestation or the signature is illegible.

For example, if an order is illegible or incomplete, NGS can throw out the documentation and therefore deny payment for the service or the entire hospital stay, Rice says. The remittance advice, which is a general billing statement routinely generated after claims processing and claims submission, can be issued for pre-payment audits, post-payment audits and routine claims submission where no items are being questioned.

“The remittance advice caught our eye because it was the first time we saw the strong language reinforcing the need to have clear, complete documentation appear on this type of communication,” Rice says. “Prior to this we were only seeing messages in the manuals, transmittals and general memos” from Medicare contractors.

Here are Rice’s suggestions for improving compliance with Medicare signature requirements:

1. **Review all forms, orders, requisitions that serve as orders** and electronic medical record screens to make sure they have a place for physicians and other caregivers to put the date, time and signature. Ideally, they will be on the same line or in the same location.

2. **Post signs everywhere** — nursing stations, charting areas, dictation rooms, transcription areas, physician lounges — to remind physicians and staff to sign, time and date their medical-record entries, to do it legibly, and to authenticate verbal orders.

3. **Install clocks in all areas where physicians and staff do charting** (e.g., transcription areas, physician lounges, patient rooms) to remove any hurdle to the timing of orders and entries.

4. **Minimize the use of verbal orders.** “Emphasize that verbal orders should be rare,” Rice says. CMS never meant for verbal orders to be used for the sake of a physician’s convenience (i.e., phone in the order and do the written version a day or two later, when it fits his or her schedule). Sec. 482.23 of the conditions of participation states: “If verbal orders are used, they are to be used infrequently.” Rice recommends that compliance officers determine how verbal orders are used at their hospitals. Often, community physicians make verbal orders — for admissions, tests or procedures — but they may not be frequent admitters. If they aren’t doing a lot of rounding, the hospital will have trouble complying with the 48-hour authentication deadline. “That’s a hard practice to fix because the community physicians may use verbal
orders as a convenience,” she says. Solutions for noncompliance with verbal order authentication include: faxed orders; electronic order entry (where physicians have their own e-signature); standing protocols for certain services; and the use of employed hospitalists, who are always on-site to sign, date and time their orders.

(5) Codify documentation compliance in the medical staff bylaws, which means physicians formally agree to abide by documentation regulations. “Facilities across the country are defining ‘complete documentation’ and putting it into the medical staff bylaws,” Rice says. The definition of “complete documentation” includes the physician’s signature, the date and time of the order or entry, and timely authentication — all written legibly. Incorporating documentation standards into the medical staff’s rules and regulations gives hospitals and medical-staff leadership the muscle to cite physicians for deficiencies and to discipline them if necessary. “The hospital gets denied payment when physicians don’t document properly and the only tool hospitals have is disciplinary action,” Rice says. This is the same approach hospitals now use when physicians miss the deadline for completion of medical records within 30 days of the patient’s discharge, another condition of Medicare participation.

(6) Put Medicare signature and other documentation requirements in contracts with physicians, whether employment contracts, medical directorships or other arrangements. Define in the contract what complete documentation means, and spell out the consequences for physicians who drop the ball, which can translate into loss of reimbursement, or worse, for the hospital. For example, a contract can state that when the hospital is denied reimbursement because the physician didn’t sign, date and time an order, the physician also will experience a payment cut. And if there is a pattern of documentation failures, the hospital can terminate the physician.

(7) Educate physicians but be patient because getting them to pay close attention to underlying documentation requires “culture change,” Rice says. “It’s about [resetting] the cultural mindset across our system, not just dollars and cents, but looking at it from the perspective of a matter of patient justice, quality and safety.”

(8) Audit your medical records for compliance with Medicare signature requirements. Rice says hospitals don’t necessarily have to engage in a separate audit. For example, a review of sign-date-timing-authentication compliance can be conducted as part of a medical-necessity audit. “While the chart is open anyway, have someone spot check it,” Rice says.

CMS Cites Medical-Necessity Problems With 17 DRGs, Urges Better Documentation

In fall 2010 guidance, CMS warns hospitals that 17 DRGs are at high risk of claims denial because “the services were not medically necessary for the setting billed.”

Patients could have been treated in a less-intensive setting, such as observation, rather than an inpatient bed — or at least that’s what the documentation indicates in the claims analyzed by recovery audit contractors (RACs) — CMS said in a fall 2010 MLN Matters article (SE 1027).

To support admissions, hospitals should ensure that their documentation is legible and complete, CMS states, and that “all fields on documentation tools (such as assessments, flow
sheets, checklists, etc.) are completed,” which is probably a reference to electronic medical record integrity.

CMS described the dollar impact of site-of-service errors with the DRGs, such as digestive disorders and cardiac defibrillator implants, during the three-year RAC demonstration. The DRGs cited in the MLN Matters are among the DRGs now targeted by the four RACs in the national program. CMS says it’s providing the information on “high dollar improper payment vulnerabilities” to educate hospitals and help them prevent the same problems down the road.

Both RACs and Medicare administrative contractors are scrutinizing these DRGs, so documentation should be a top compliance priority.

But the astronomical improper payments cited by CMS in the article aren’t necessarily the final word. Because the figures listed represent pre-appeal dollars, some of the denied claims may have been overturned in hospitals’ favor through Medicare appeals.

“Our experience in the Medicare appeals process suggests that many of the denials associated with target areas high on the [MLN Matters] list, such as cardiac defibrillator implantation, heart failure and chest pain, were reversed in the appeals process — especially at the administrative law judge level,” says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia. “Providers should assess each denied claim on its individual merits. While lists of high-risk DRG targets such as these are good starting points for providers initiating self-audits, the inclusion or absence of a particular DRG on a list of high-risk targets should not be the definitive factor for providers who are considering appeal.

### High-Risk DRGs: CMS List of Common Site-of-Service Errors

In a new MLN Matters article (SE1027), CMS lists some of the DRGs that were prone to claims denials during the RAC demonstration because documentation did not support an inpatient level of care. Many of these DRGs are now appearing on the four national RACs’ target lists. To read the article, go to AIS’s Government Resources at the Compliance Channel at www.AISHealth.com; click on “CMS’s MLN Articles.”

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Improper Payment Amount (Pre-appeal)</th>
<th>RAC Demonstration Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>$64,739,662</td>
<td>Cardiac Defibrillator Implant (DRG 514/515)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$34,155,158</td>
<td>Heart Failure and Shock (DRG 127)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$21,956,139</td>
<td>Other Cardiac Pacemaker Implantation (DRG 116)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$19,169,815</td>
<td>Chest Pain (DRG 143)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$14,374,696</td>
<td>Misc. Digestive Disorders (DRG 182)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$13,881,479</td>
<td>Other Vascular Procedure (DRG 478)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$10,359,085</td>
<td>COPD (DRG 88)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$9,978,346</td>
<td>Medical Back Problems (DRG 243)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$7,355,002</td>
<td>Nutritional &amp; Misc. Metabolic Disorders (DRG 296)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$6,979,129</td>
<td>Transient Ischemia (DRG 524)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$6,228,919</td>
<td>Other Circulatory System Diagnoses (DRG 144)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$4,758,678</td>
<td>Kidney &amp; UTI (DRG 320)</td>
</tr>
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<td>Inpatient Hospital</td>
<td>$3,239,751</td>
<td>Cardiac Arrhythmia (with CC DRG-138)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$2,912,155</td>
<td>Degenerative Nervous System Disorders (DRG 012)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$2,889,840</td>
<td>Atherosclerosis (with CC DRG-132)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$2,545,289</td>
<td>Other Digestive System Diagnosis (DRG 188)</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$2,314,001</td>
<td>Percutaneous Cardiac Procedure (DRG 517)</td>
</tr>
</tbody>
</table>
The decision whether or not to appeal a denial should be made based on the clinical and legal merits of the case.”

CMS says inpatient claims for the high-risk DRGs were often denied because medical records didn’t have enough information to support the diagnosis, justify treatment and/or procedures, document the course of care, identify the results of treatment or diagnostic tests, and facilitate continuity of care among providers.

“Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting,” the article notes. (See Chapter 6, Section 6.5.2 of Medicare’s Program Integrity Manual at www.cms.gov/manuals/downloads/pim83c06.pdf.)

One of the DRGs on the CMS high-risk list is medical back problems, which is a long-time medical-necessity target of Medicare auditors. Because many back-pain patients can be treated as outpatients, documentation must thoroughly establish when admissions for this DRG are warranted, Taylor says. Legitimate reasons for inpatient treatment of back problems could include potential injuries to the nervous system that endanger the patient’s spinal cord, causing paralysis or weakness of extremities, Taylor says.

“It’s important in the documentation to differentiate potential neurological injuries or injuries that require more intensive care from lower-intensity pain or muscle spasms that indicate far less risk to patients,” he says. Sometimes hospitals mistakenly think patients meet inpatient admission criteria (e.g., InterQual) for medical back problems when they don’t. The patient may not be ambulating due to pain and muscle spasm, “but that’s not true paralysis,” Taylor says. “The admission criteria frequently look toward neurological injury rather than ambulatory dysfunction due to lumbar muscle spasm and pain. Hospitals that fail to differentiate between those two groups of patients [may face denials for medical back problems].”

**Pain Management Can Be Tricky**

It is also important to be wary of admissions for pain management. “We see some hospitals routinely admitting patients for low-risk, low-intensity, short-duration pain control,” Taylor says. Patients who require prolonged or high doses of intravenous narcotics may be appropriate admissions, especially if they have comorbid conditions, he says. But many patients can be treated with oral medications in the emergency department or with observation services. Whichever route you choose, “the physician has to evaluate each patient on a case-by-case basis and arrive at an informed decision and document very thoroughly to demonstrate the rationale behind his or her admission status decision,” Taylor says.

Another DRG on the CMS high-risk list is cardiac defibrillator implant, a surgical DRG. Implantable cardiac defibrillators are small electronic devices that shock the heart during life-threatening tachyarrhythmias (abnormal electronic activity). They have attracted the attention of the Department of Justice, which is investigating hospitals in multiple states for cardiac defibrillator surgery, apparently both over medical necessity and DRG coding.

Taylor says hospitals must ensure that their documentation shows the patient needs the device and that the correct setting — inpatient or outpatient — was the right choice for the sur-
gery. “You have to document both the initial need for the defibrillator implant and the correct status,” he says.

The chart also has to show that patients meet the Medicare national coverage determination (NCD) for cardiac defibrillator implants, Taylor says. “If you don’t meet that, Medicare won’t pay for the procedure,” he says. The NCD (20.4) describes the conditions for which Medicare covers cardiac defibrillator implantation (e.g., cardiac arrest due to ventricular fibrillation; coronary artery disease with a documented prior myocardial infarction; documented sustained ventricular tachyarrhythmia).

When Taylor examines hospital charts, he sometimes finds that physicians fail to explicitly communicate the extent of the patient’s heart failure. “Physicians have to describe exactly what procedure is being performed,” he says. For example, if the patient needs a dual-chamber device, physicians should describe the reasons why — especially if the patient needs biventricular devices for resynchronization therapy,” which provides electrical stimulation to both chambers of the heart. “The physician has to document that the patient had such severe congestive heart failure that resynchronization is appropriate therapy, which requires in-depth notes on the degree and severity of the heart failure,” he says. Beyond that, physicians must document comorbidities (i.e., other illnesses) that affect treatment and site-of-service decisions. Is the patient at high risk because of unstable medical conditions, such as uncontrolled diabetes or renal failure? “Without that specific level of documentation, hospitals could be denied for that admission,” Taylor explains.

The DRG for transient ischemia, which means the brain briefly received inadequate oxygen, is also on the CMS hot seat, according to the MLN Matters article. Transient ischemia “can be a very dangerous situation, but some patients may be at much higher risk than others, so it’s important to document clinical details,” Taylor says, such as:

◆ The duration of a patient’s symptoms;
◆ The patient’s age;
◆ The exact clinical features of the symptoms;
◆ The patient’s blood pressure;
◆ The patient’s other comorbidities; and
◆ Risk factors. For example, does the patient have a history of cardiovascular or cerebrovascular disease? Is there a history of ischemia (restriction of blood supply)? Does the patient have diabetes mellitus?

**Physicians Should Make the Decisions**

Whether the patient is treated in an inpatient versus outpatient setting is a decision the physician should make on a case-by-case basis. “You can’t have a one-size-fits-all approach.” It’s important to use evidence-based medicine, he adds. “Often these patients need close monitoring as well as aggressive diagnostic assessment and, in some cases, if certain problems are identified, such as acute obstruction, they may need much more aggressive treatment,” Taylor says. While all this assessment and monitoring is going on, clinicians don’t even know if the DRG will be transient ischemia. It could very well turn into a stroke. “Their DRG is not assigned yet,” he notes. Given the fluid nature of the diagnosis, “you have to document the clinical details thoroughly to demonstrate the presence of medical necessity. Clinicians should document everything and let the coder sort out the DRG on the back end,” he advises.
Recent FAQ on RAC Re-reviews Has Some Scratching Their Heads

A response to a frequently asked question (FAQ) posted on the CMS website may generate more questions than answers about whether recovery audit contractors (RACs) can take a second look at claims they have already reviewed.

The FAQ, posted Nov. 2, 2010, asks, “Can a recovery audit contractor (RAC) review a claim more than once?” CMS answers, “Yes.”

“The RAC can review a claim either through automated or complex review more than once,” the FAQ says. “The exact claim line cannot be reviewed more than once, but the RAC may review different claim lines in separate reviews.” The RAC also could do a DRG-validation review and then separately request documentation to complete a medical-necessity review, CMS adds.

“The reason [RACs] don’t do it all at once is that they can only [review something] if it is on the issues-approved list,” says Michigan attorney Andrew Wachler, with Wachler & Associates, P.C. “So if they’re doing DRG validation now, and medical necessity is not approved yet, it may be that they come back a second time once it’s approved to look at medical necessity.”

But RAC experts are raising questions about CMS’s use of the phrase “claim line.”

Robert Jacobs, president of Health/ROI in Lake Success, N.Y., says the language is confusing. He’s picking apart the FAQ similar to the way T.V. detective Columbo would, starting with “What does CMS mean by a claim line?”

“They could mean they have a physician’s or some other bill within an inpatient bill, and they can review that two different ways. I’m just not sure what they mean,” he says.

Wachler also questions the meaning of a claim line. “If I’m looking at a particular service, and they look at it from a DRG perspective,…can they come back and audit that for medical necessity? Is that a different claim line? It seems like the same claim line, but a different rationale for denial,” he tells AIS.

But Boston attorney Larry Vernaglia, with Foley & Lardner LLP, says he thinks this is consistent with what was said during the RAC demonstration. “They can’t revisit the same issue twice, but if a given claim has two issues, they can look at it once for the first issue and another time for the second issue,” he tells AIS. “This makes it very important for hospitals, physician groups and other providers to keep very clear records of the reasons the RACs are reviewing claims, not only for the reason of assuring against the ‘double take,’ but also because RACs need ‘good cause’ to reopen a claim.”

Ellen Scott, Health/ROI’s director of appeals management service, points out that the scope of work for RACs does not allow them to look at claims that are being reviewed by other CMS auditors, but it doesn’t indicate whether they can re-review claims.

Scott also contends that CMS is contradicting itself with this new FAQ. In April 2010, CMS released an FAQ (Answer ID 10007) saying that RACs would not be allowed to take a second look at the same claim. “Can the [RAC] do a medical necessity review on a claim that they originally reviewed for DRG validation?” the April 2010 FAQ asked. “At this time, if the RAC has already requested documentation and issued a review results letter to the provider for a
DRG validation, the RAC will not be allowed to re-review the claim again for medical necessity,” CMS answered. “However, if both issues are approved (DRG validation and medical necessity) prior to the request of the additional documentation, the RAC may conduct both reviews simultaneously.”

Whatever the outcome of this debate, providers need to have systems in place to make sure they are coding correctly for DRGs, says Wachler. “They have to educate themselves on the criteria for inpatient versus outpatient observation, exercise some reasonable discretion in terms of how a patient should be admitted and document in the medical record to support inpatient admission, so when they are reviewed, they can defend it, and hopefully that will lead to fewer denials.”

**CMS Modifies Additional Documentation Limits**

CMS said on Nov. 10, 2010, that it has modified the limits on additional documentation that recovery audit contractors (RACs) can request from providers.

As of Nov. 2, 2010, the cap is 300 additional documentation requests per 45 days for all providers. The limits will be set by each RAC and will include a per-campus cap on the maximum number of medical records that may be requested in a 45-day period. The limits will be based on the provider’s tax identification number (TIN) and the ZIP code where the provider is physically located.

Using the TIN will reduce the total number of limits that would have been imposed per organization under an earlier policy, which used national provider identifiers. Use of the ZIP code will promote equitability for regional or national organizations, CMS explained. Also, documentation limits will be set at 1% of all claims submitted for the previous calendar year, divided into eight periods (45 days).

The limit will be applied across all claim types, including professional services, CMS said. RACs can exercise discretion in the makeup of their request. For example, a RAC could request inpatient records up to the full limit even if the provider’s inpatient business is only a small portion of its claims volume.

**CMS Will Now Be Tracking Certain Overpayments From MACs**

Information about providers’ payment errors soon will be flying back and forth among the program-integrity players under a new CMS policy.

According to Transmittal 360, Medicare administrative contractors (MACs), fiscal intermediaries and carriers must start reporting corrective actions and overpayment collections to CMS every quarter starting in March 2011. CMS will let MACs, FIs and carriers know which service-specific errors or vulnerabilities they should report on.

“CMS takes vulnerability resolution through corrective action very seriously and requires a formal feedback mechanism to track corrective actions and overpayment recovery actions taken by the ACs and MACs,” according to the transmittal (Change Request 7241), which is
dated Dec. 10, 2010. CMS will select errors and vulnerabilities based on the work of recovery audit contractors (RACs), the comprehensive error rate testing (CERT) program, internal CMS analysis and HHS Office of Inspector General audits.

With program-integrity information about to go viral, providers may face more takebacks, says Robert Jacobs, president of Health/ROI in Lake Success, N.Y. As a result, providers should continue to appeal all claims denials that are either unfounded or in a gray area, according to Jacobs and Ellen Scott, director of the appeals management service at Health/ROI.

**RACs Have ‘Pushed the Envelope’**

“We have seen RACs push the envelope with admission denials, where the physician potentially could have gone either way by diagnosis [inpatient or outpatient], but determined a high risk of complication or a non-predictable outcome and therefore admitted the patient to the inpatient service. Appeal it. But if you made a mistake, write a check,” Scott says.

As Medicare watchdogs feel the pressure to recover more overpayments, hospitals should self-audit obvious targets, such as excisional debridement, based on actual RAC experience. “Evaluate whether you have a problem” in terms of documenting the term “excisional” when it was a surgical procedure (CPT code 86.22), Jacobs says. “If you do have a problem, ask the doctor who did the procedure to write an addendum based on the chart. Don’t wait for the RAC to show up. The closer this self-audit process is to the date of service the more effective it can be.” The self-audit process should be used to determine if there is ambiguity in the documentation and, where appropriate, to fix it, Jacobs and Scott say.

Also, audit preparation and strategy teams should not be organized exclusively around the RACs, Jacobs and Scott say. They advise hospitals to coordinate their defense of all contractor audits — RACs, MACs, zone program integrity contractors, Medicaid integrity contractors, RAC-like auditors used by Medicare HMOs and perhaps private payers. Some hospitals have already embraced an all-payer defense audit approach and developed tools to track their interactions with auditors.

It’s also important to have proper controls for tracking the claims that were put under an external auditor’s microscope. With so many different program-integrity players at work, CMS has pledged they will not audit the same claim. “Keep a database of all cases that were reviewed, even if you win, so when the next government agent shows up, you say ‘you can’t touch that case,’” Jacobs says. “They are not supposed to touch a case twice.”

**Malnutrition Complications Under Scrutiny at Hospitals, Risking MS-DRG Downcoding**

There’s more to malnutrition than meets the eye, and Medicare auditors, including recovery audit contractors (RACs), are on the lookout for mistakes in this area. Hospitals may find their MS-DRG claims denied or downgraded unless physicians understand and document the distinctions between degrees of malnutrition and coders capture them accordingly.

“You’ve got to distinguish between the different forms of malnutrition,” says certified coder Donna Wilson, senior director at Compliance Concepts, a consulting firm in Wexford, Pa.
This is a challenging area because some of the documentation distinctions between the forms of malnutrition are subtle, says Gloryanne Bryant, regional managing director of the health information management and revenue cycle departments at Kaiser Foundation Health Plan and Hospitals in Oakland, Calif. “The increased frequency of certain malnutrition codes could be a red flag for RACs.” For example, the phrase “protein malnutrition” codes to kwashiorkor, a diagnosis of virtual starvation far more common in third-world countries than in America. “Physicians don’t realize that by documenting ‘protein malnutrition,’ they are giving patients a condition not typically seen in the U.S.,” says Bryant. But throw in one word — calorie — and the diagnosis is “protein calorie malnutrition,” which codes to something else entirely, with different MS-DRG payment ramifications. Although kwashiorkor is not an inconceivable diagnosis, there’s a good chance that it’s wrongly reported and therefore may wreak havoc with complications and comorbidities under MS-DRG reimbursement and possibly skew diagnosis-driven payments from Medicare Part C. One hospital fought a RAC denial over a severe form of malnutrition and won.

The inherent complexity of malnutrition makes it a tough nut to crack, Wilson said in March 2011. “Physicians are writing protein malnutrition and that’s what coders are putting into claims,” she says. “Educate physicians and coders on proper documentation for malnutrition.”

Malnutrition is a potential RAC target in terms of its status as a complication/comorbidity (CC) and major CC (MCC). MS-DRGs are based first on the principal diagnosis, the condition found after study to be mainly responsible for occasioning the hospital admission. But reimbursement is increased by Medicare CCs and MCCs, which are secondary diagnoses that reflect greater patient severity and require more hospital resources. CCs and MCCs increase the relative weight of the MS-DRG and therefore the reimbursement.

Different types of malnutrition can be either a CC or MCC, both of which affect the MS-DRG payment if they are the only CC or MCC in the record. Kwashiorkor, ICD-9-CM code 260, is a real standout because it’s such a severe diagnosis and prompts significantly more MS-DRG reimbursement, Bryant says.

Because of the ostensibly subtle differences between types and subtypes of malnutrition, which affect their status as a CC or MCC, it’s important to understand the variations of malnutrition diagnosis codes, according to Bryant and Wilson:

- **ICD-9 code 260 is kwashiorkor.** It’s an MCC, which means it’s a secondary diagnosis that triggers the greatest payment for an MS-DRG if it’s the only MCC.
- **ICD-9 code 261 is nutritional marasmus.** The extent of the malnutrition in this category is significant for clinical and reimbursement purposes, and it’s an MCC.
- **ICD-9 code 262 is severe protein calorie malnutrition,** and an MCC.
- **ICD-9 code 263 is other and unspecified protein-calorie malnutrition** and contains these subcategory codes: 263.0 is moderate malnutrition and 263.1 is mild malnutrition, neither of which are CCs or MCCs; 263.8 is other protein calorie malnutrition and a CC; 263.9 is unspecified protein-calorie malnutrition and also is a CC; and 263.2 is arrested development following protein-calorie malnutrition and is a CC.

More guidance in this area is available from the third quarter 2009 issue of Coding Clinic, the newsletter published by the American Hospital Assn.
Five Steps Recommended to Reduce Errors

Bryant suggests the following five documentation and coding steps to reduce malnutrition-related errors:

1. **Run a data report on inpatient cases (especially Medicare) with the ICD-9 260 code.** Go as far back as October 2007, which is the “look-back” period for RACs, prior to which they can’t audit claims, she says. “If you find cases with the 260 code assigned, they should be reviewed for documentation accuracy,” and to ensure the clinical components of the treatment exist in the medical record to support the code and classification.

2. **When reviewing medical records with kwashiorkor, include a validation of the clinical indicators and coding.** For example, was the patient a child or adult? Kwashiorkor is more common in kids. Did the patient have excessive carbohydrate intake, skin abnormalities, protein deficiencies and liver disease, which are all hallmarks of kwashiorkor? If that’s the case, maybe the patient does have it. But the code assignment must have plenty of support from clinical indicators to fend off auditors and internal scrutiny, Bryant says, and hospital officials should determine whether additional examination is needed regarding the terminology used by the physician. If the documentation states only “protein malnutrition,” Bryant says the physician should be queried for clarification.

3. **Query the physician who diagnosed kwashiorkor, Bryant says.** Explain that documentation of the term “protein malnutrition” codes to kwashiorkor, but it’s very rare in the U.S. and usually seen in children abroad. Ask the physician to clarify whether the condition is truly kwashiorkor versus protein-calorie malnutrition; mild, moderate or severe malnutrition; or malnutrition not otherwise specified. “It is best not to code 260 without clarification of actual kwashiorkor from the physician,” Bryant notes.

4. **Use a physician query that explains the malnutrition options and offers the physician choices so they understand the malnutrition classifications, she says.** For example, the query could state:

Dear Dr. XX: You have documented “protein malnutrition,” which ICD-9-CM classifies to “kwashiorkor,” a rare syndrome occurring mostly in starving children. Please clarify whether your patient had kwashiorkor, or whether they had “protein-calorie malnutrition” (include the degree), “malnutrition unspecified,” or some other nutritional diagnosis (please specify) __________. Thank you.

5. **Share malnutrition information with coding and clinical documentation improvement (CDI) staffers who query or clarify physicians’ nutritional diagnoses, Bryant advises.**

Wilson says kwashiorkor errors can be reduced by the use of certain encoders, which is coding software that helps coders assign the proper code. “Coding prompts/alerts are available in these software programs to allow the coder to stop and think before assigning an improper code,” Wilson says.

For example, she says the 3M encoder has questions to make coders think twice about assigning kwashiorkor. When coding “protein malnutrition,” the encoder asks the coder this question: “Does physician documentation support kwashiorkor?” The 3M encoder also has a message appearing that says: “Code 260 (kwashiorkor malnutrition) is EXTREMELY RARE in the United States and should only be coded when the physician specifically documents this condition. Code category 263 malnutrition includes protein-calorie. When protein malnutri-
tion is described by the degree or severity (mild, moderate, severe), then only the code for the severity should be assigned. Example: Moderate protein malnutrition is coded as 263.0 only. See AHA Coding Clinic, 3rd QTR, 2009, page 6.”

**RACs Launch New Semi-Automated Reviews That Require Hospital Documentation**

Recovery audit contractors (RACs) have debuted a new type of overpayment identification — “semi-automated reviews” — that require hospitals to submit documentation if they want to rebut a presumption that their claims are invalid.

Semi-automated reviews sound like automated reviews because they are based on CMS claims analysis and appear to steer clear of MS-DRG coding validation and medical necessity. But semi-automated reviews may have more in common with complex reviews because hospitals must submit medical records unless they’re willing to sacrifice their reimbursement without a fight.

The great unknown is whether there’s a cap on the number of semi-automated reviews that RACs can perform at each hospital, said Heidi Shirk, RAC program coordinator for Penn State Milton Hershey Medical Center in Hershey, Pa., in April 2011.

RACs can do unlimited automated reviews because hospitals aren’t required to submit medical records as a part of the process, unless they appeal. However, CMS caps the number of complex reviews RACs may conduct every 45 days, because providers would otherwise be crushed by the demands of medical-record production inherent in this type of audit. The cap varies by provider type, although recently CMS upped the limit to 500 per hospital every 45 days. CMS has not indicated whether there’s a ceiling for semi-automated reviews, and CMS officials in charge of the RAC program did not respond to requests for an interview.

According to the CMS website, there are two parts to semi-automated reviews:

1. **The RAC’s automated review process identifies a billing aberration** with a “high index of suspicion to be an improper payment.”

2. **The provider gets a “notification letter”** from the RAC, which explains the existence of the potential billing error. The RAC gives the provider 45 days to produce documentation to support the claim. If the RAC agrees with the provider, all is good. However, CMS says, “if the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued.” In other words, the claim will be denied.

“My concern is volume and my fear is they won’t have a cap,” Shirk says. “I hope CMS keeps in mind that there is no cap on automated reviews. They should take into consideration how many medical records they are asking for so they don’t put a huge burden on facilities.”

Certain types of claims seem ripe for semi-automated reviews because they fall through the cracks of automated reviews (which don’t use medical records) but are not complex review material (because they are not MS-DRG or medical necessity-related), Shirk says. A big one is modifier 59, which physicians and hospitals use to override Correct Coding Initiative (CCI)
CCI edits are designed to prevent inappropriate coding that causes Medicare overpayments. Medicare won’t pay separately for certain services when they are performed on the same patient at the same time. But providers can override edits with modifier 59. Suppose the physician performs (1) adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 square cm or less (CPT 14040) and (2) repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm (CPT 13131).

“If these codes are billed together on the same claim — same date of service — you will receive an unbundling edit,” Shirk says. But providers are allowed to override the edit with modifier 59 if documentation supports the fact that separate services took place, she says. For example, modifier 59 is justified when a physician performs both procedures on the patient’s forehead and chin at the same time. “What the RACs would be looking for is the separateness to warrant being paid for both,” she notes.

Semi-automated reviews are also tailor-made for medically unlikely edits (MUEs). CMS uses MUEs to block payment for services that, on their face, don’t make sense, and has assigned a maximum allowable number of times providers can bill for certain CPT codes. “They’re just arbitrary numbers, but it’s unlikely to happen” beyond that number, Shirk says. For example, CMS assigned three MUE units for incision and drainage of post-op wound infections. That means providers can’t bill more than three of these procedures on each patient per date of service. It’s conceivable it would be justified, however, so Shirk says that hospitals may want to fight back if RACs hit MUEs during semi-automated reviews.

Shirk emphasizes she is speculating that modifier 59 and MUEs could be targets for semi-automated reviews. Until they occur, or CMS or the RACs provide more information, there’s no way to know.

Wendy Trout, director of corporate compliance and revenue management at WellSpan, thinks semi-automated reviews sound promising. She thinks there will be more clarity than hospitals have experienced so far with automated reviews, in which the RAC sends vague demand letters stating an overpayment amount and a general reason (e.g., denied due to CCI edits) without specifying which line items were implicated. That forces hospitals to decipher which line items were denied and, if indicated, to set the RAC straight during the discussion period — and to do all that within 45 days. Automated reviews were supposed to be black and white — simple errors, such as billing for three cataract surgeries — but it hasn’t turned out that way, Trout says. Hospitals wind up chasing down money that Medicare recouped inappropriately from RAC automated reviews, which is “an administrative nightmare.”
Facing RACs: Strategies for Success

Hospitals Move to Combine the Tracking of External Audit Demands

With hundreds of medical-record requests pouring in from various Medicare and Medicaid reviewers, some hospitals are developing management processes that incorporate more than requests from recovery audit contractors (RACs).

For example, WellSpan Health in York, Pa., is moving all requests for information from Medicare, Medicaid and commercial-insurance reviewers and auditors to its new automated tracking system. The software, which was designed just for RAC tracking, is now a central repository for critical information about the audit interaction between WellSpan and Medicare and Medicaid reviewers and program-integrity contractors, and lets WellSpan massage its own data for internal audit purposes, said compliance officer Wendy Trout in May 2010.

But Trout says she had to motivate her vendor to push its software beyond RAC tracking by considering switching to another vendor. “All the vendors we looked at were focused just on the RAC piece, but that is just a small piece of what we defend,” she says. “That’s why we pushed our vendor to capture other types of reviews.”

Because all the information is in one place, “there can be one central responsible person” in charge of it, says Trout, who runs the show. Until now, one nurse auditor would handle additional documentation requests (ADRs) from the Medicare administrative contractor and another nurse auditor handled the comprehensive error rate testing (CERT) program requests. Still another person logged in RAC documentation demands. “There were multiple hands in the pot and no way for me to know if everything was getting done” (e.g., meeting submission deadlines), Trout says. And she wouldn’t always know audit results because they were followed by different people with data housed in different systems or tracked in paper files.

The More Connectivity, the Better

So far, WellSpan tracks interactions with the RAC; the state’s Medicaid program-integrity contractor, CGI Federal; the Medicaid Bureau of Program Integrity; and the MAC, which sends ADRs and special requests. “We are close to getting the CERT contractor in there and then we will add all Medicare and Medicaid HMO reviews and commercial reviews,” she says. If a zone program integrity contractor (ZPIC) demand comes in, that will be added to the tool as well.

The new software monitors when documentation requests arrive, when the records are sent to the reviewer, what the findings are, the type of audit, the number of dollars at stake, the hospital department, the codes and units of services billed, and the names of the admitting physicians and coders. “I am monitoring reports to make sure we are making deadlines and things are not falling through the cracks,” she says. WellSpan also can slice and dice all of this data to identify problems internally.

Trout encourages other compliance officers to urge vendors to make the tracking software responsive to all of their demands. Also, “look for vendors with connectivity to others,” she
says. For example, CGI Federal has a portal with WellSpan’s vendor. As a result, “when they know we have released documents for review, they can log in and view them. No paper has to be produced,” she says. And it’s helpful if vendors have connectivity to consultants who help with appeals of claims denials (e.g., medical necessity complex reviews).

In fact, CMS is setting up a pilot program to connect vendors to the National Health Information Network (NHIN). WellSpan has agreed to participate, with a tentative test date set for Nov. 30, 2010. “Once we have this going, we’ll be able to send our RAC requests and many other government audits via this electronic submission method,” Trout explains. The second phase will make the back-and-forth of documentation requests and responses between providers and Medicare contractors fully electronic.

WellSpan also took a different approach to the Medicaid auditor’s demand for 241 medical records. Because of the burden of producing that much documentation, Trout invited CGI to review them on-site. For a week, Medicaid reviewers sat at WellSpan computers and reviewed medical records in the electronic health record system. The verdict so far: 137 cases got a clean bill of health, and CGI asked for hard copies of 82 others.

Trout says she was ambivalent about the on-site review. Did WellSpan really want program-integrity auditors sitting in the medical records department for a week? And there were logistical challenges with getting them set up on the EHR system. “But it’s worked out and cuts down on costs and reduces the burden on an already overworked staff,” she says. ♦

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**Form for Tracking Medical-Records and Information Requests**

Wendy Trout, compliance officer at WellSpan Health in York, Pa., developed this form to track medical-records and release of information requests from all Medicare auditors and program integrity contractors. WellSpan’s recovery audit contractor tracking software vendor is also building the form into its system.

Name (what you wish to call this audit type): ____________________________________________________________________________

Name of auditors: ___________________________________________________________________________________________________

Address to ship records: _____________________________________________________________________________________________

______________________________________________________________________________________________

TIMEFRAMES: ______________________________________________________________________________________________________

Records due (# of days from request): _________________________________________________________________________________

Auditor deadline for review & results back (# of days or none): ______________________________________________________________

APPEALS

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Reviewers Challenge Physician Diagnoses, Procedures as Audits Take a New Turn

Complex reviews are getting a whole lot more complex, as some Medicare reviewers reportedly wade deeper into medical decision making.

DRG validations and medical-necessity audits are being performed at a level never seen before, several experts said in late 2010. Some recovery audit contractors, RAC-like auditors, Medicare administrative contractors (MACs) and Medicare quality improvement organizations (QIOs) are denying claims because they disagree with the physician’s conclusions about a patient’s condition or the need for a procedure. In some cases, claims are being denied because the physician didn’t base the diagnosis on clinical guidelines even when their use is not required by Medicare, sources tell AIS.

“In the past, auditors focused on whether charts contained physician orders, and whether they were signed and dated and specific to the services delivered,” says Kevin Cornish, national director of the health care dispute, compliance and investigation practice for Navigant Consulting. “Now it’s ‘what was the diagnosis, what was the history, what tests were run, what decisions were made in terms of the procedures performed, and was it consistent with Medicare requirements?’”

Becky Cornett, Ph.D., director of fiscal integrity at Ohio State University Medical Center, has noticed that audits are going beyond the usual documentation expectations. Her health information management department says that RACs are not sticking to coding guidelines, which allow coders to code whatever the physician diagnosed. “DRG validation is now about coding and the validity of the physician’s diagnosis,” Cornett says.

In fact, DRG validation has become a vehicle to challenge physician diagnoses, says physician/attorney Paul Weygandt, vice president of physician services for J.A. Thomas & Associates, a compliance consulting and clinical documentation improvement firm. Although DRG validation generally involves auditing documentation to determine if principal and secondary diagnosis coding is accurate, there’s apparently enough wiggle room, in Medicare’s eyes, to also question the diagnosis, he says. CMS says that “the purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the patient, as coded and reported by the hospital on its claim, matches both the attending physician’s description and the information contained in the patient’s medical record.”

Reviewers are “increasingly challenging the appropriateness of coding diagnoses well-documented in the medical record,” Weygandt says. For example, a QIO recently reversed the diagnosis of a treating physician, which resulted in lower DRG reimbursement for the hospital. The case was coded based on the physician’s diagnosis of encephalopathy. The reviewer disagreed on the grounds that “the medical documentation supports a worsening of [the patient’s] Alzheimer’s disease more than acute encephalopathy [due to sepsis].” Even though the treating physician (1) documented that the patient had an acute change in neurologic status, which is atypical for Alzheimer’s disease, and (2) explicitly stated that “the patient does have a clinical picture of sepsis and encephalopathy,” the reviewer changed the diagnosis, he says. The only explanation that makes sense is money, he contends. Septic encephalopathy is a major comorbidity, so it increases the DRG payment, but exacerbation of Alzheimer’s disease is not even a minor comorbidity. Weygandt wonders whether this is “an attempt to change di-
agnoses by treating physicians under the label of DRG validation simply to decrease payment by the federal government.”

**Winning an Appeal Is Not a Great Outcome**

Hospitals are often able to reverse these denials, but that’s cold comfort, he maintains. “A lot of these denials are being challenged and won on appeal, and people think that’s a great outcome, but it’s not,” he says. “We are expending limited resources pushing paper.”

Meanwhile, some RACs and RAC-like auditors (used by Medicare HMOs) are downcoding or denying claims because physicians didn’t use certain clinical criteria, Cornett says. They are discounting complications and comorbidities (CCs) and major CCs (MCCs). “RACs are saying ‘we won’t allow this CC or MCC because you didn’t use evidence-based criteria’” to diagnose the patient. She speculates this may be a back-door way to advance the use of clinical guidelines.

For example, acute renal failure is vulnerable to downcoding by RACs and other auditors if physicians don’t use clinical guidelines. There is a big bull’s-eye on acute renal failure because it’s been the most popular MCC for three years, says Robert Gold, M.D., president of DCBA Inc., a clinical documentation consulting firm in Atlanta. Although Medicare doesn’t mandate the use of specific guidelines for acute renal failure, some auditors are denying claims if physicians fail to use “RIFLE” criteria. RIFLE — an acronym for risk, injury, failure, loss and end-stage renal disease — is a frequently used tool for assessing renal dysfunction. But it’s not the only one and, in fact, Weygandt and Gold say that it’s being superseded by the Acute Kidney Injury Network’s (AKIN) criteria for diagnosing acute renal failure. Physicians may use current clinical guidelines, but “Medicare has not formally moved to that terminology,” Weygandt says. (Acute renal failure was dropped from an MCC to a CC in October 2010, so RACs may back off after auditing claims from the three years between October 2007 and September 2010, Gold says, because the purported overpayments won’t be as alluring.)

Compliance officers are surprised to see denials based on disputes over diagnoses, especially on the grounds that physicians didn’t apply specific clinical guidelines. One hospital compliance officer, who asked not to be identified, described three claims that were downcoded because the physicians didn’t use clinical criteria:

1. The RAC-like auditor removed acute renal failure as the MCC and re-sequenced the DRG, stating that “acute renal failure does not meet RIFLE criteria.”

2. The RAC stated that the medical records don’t support acute renal failure as the secondary diagnosis. “The [Uniform Hospital Discharge Data Set] defines other or secondary diagnoses as all conditions that co-exist at time of admission that develop subsequently or affect treatment received or length of stay. Though the discharge summary states the patient had acute renal failure, the patient’s Creatinine level only reached a high of 1.333. At discharge, the Creatinine level was slightly lower at 1.19. This lab evidence does not substantiate a diagnosis of acute renal failure, which is an MCC.” Creatinine is a test to measure kidney function, and both the RIFLE and AKIN criteria use it as a sign of acute kidney failure.

3. A RAC-like auditor rejected a diagnosis of aspiration pneumonia, saying there wasn’t specific imaging evidence. The auditor contended the hospital can’t document aspiration pneumonia because it wasn’t proven the patient aspirated.
When reviewers challenge their conclusions, physicians get gun shy about documenting presumptive or probable diagnoses, which has been standard operating procedure. “Some physicians approach [documentation] defensively when they feel they have to rigidly apply lists of criteria, a practice which flies in the face of the clinical practice of documenting the physician’s clinical impression,” Weygandt says. Physicians should document “probable aspiration pneumonia” if that is the clinical diagnosis they are treating; probable aspiration pneumonia codes the same as aspiration pneumonia, so there is no negative financial consequence for expressing ambiguity. “Physicians now feel pressured not to make the diagnosis unless they can prove it.” As a result, they will document “pneumonia unspecified,” and hospitals will be paid as if patients had a lower-acuity pneumonia even when the physicians are clinically treating aspiration pneumonia, Weygandt says.

Hospitals Can Improve What They Do

Even as RACs get under their skin, hospitals have room for improvement. Gold cautions hospitals to guard against assigning diagnoses solely from lab-test results. Patients with abnormal renal function tests may just be severely dehydrated. “AKIN says if patients respond to IV fluids within six to eight hours, they probably didn’t have acute kidney injury or failure. You can’t bill by numbers on a lab result,” because Creatinine will be transiently high in these patients, Gold says. “Too many hospitals are ignoring what’s wrong with the patient and asking doctors to bill by lab results. They don’t do clinical interpretations of lab results.”

The challenges on the medical-necessity side are apparent in both audits and false claims cases. RACs and MACs are deepening their medical-necessity audits and doing more of them. “The level at which we are seeing complex medical reviews is increasing,” Cornish says. The emphasis used to be on whether providers met documentation rules, but now Medicare contractors and regulators are “critically evaluating” the medical appropriateness of the service billed “in a way they have never done.”

For example, hospitals across the country also are under investigation for billing implantable cardiac defibrillator (ICD) surgery that doesn’t meet Medicare’s national coverage determination.

“It’s a significant development,” Cornish says. “Now documentation needs to be at a higher level to help reviewers understand why certain services were provided.”

CPT Changes to Debridement May Reduce Claims Denials in Longstanding Risk Area

Debridement — the compliance monkey on everyone’s back — has undergone a CPT coding makeover that should have a ripple effect for hospitals.

As a result of CPT changes that took effect on Jan. 1, 2011, the excisional debridement audit picture may start to get prettier for hospitals, underscoring the fact that documentation and coding improvements necessary for physicians in their practices are also important for physicians in hospital records.

When it comes to debridement, there has always been a disconnect between CPT codes, which drive physician billing, and ICD-9 codes for inpatient billing, which are selected by
coders but based on physician documentation. That disconnect has been a factor in physicians not documenting the word “excisional” in hospital patients’ charts, with dire consequences for hospitals.

Recovery audit contractors (RACs) and other Medicare auditors have routinely denied claims for MS-DRGs related to excisional debridement when the magic word “excised” or “excisional” was not documented. These denials have taken place even though all other indications was that an excisional/surgical service was performed (e.g., physicians said they used a surgical knife to cut down to healthy tissue), according to John Christiano, senior consultant with National Health Resources in Great Neck, N.Y.

“Debridement” refers to the non-surgical brushing, scrubbing, whirlpool or washing of devitalized tissue, necrosis or slough. “Excisional debridement” is the surgical removal or cutting away of necrotic or devitalized tissue performed at a patient’s bedside or in the operating room. Excisional debridement pays hospitals far more than vanilla debridement.

But the changes to the 2011 CPT coding book may help close the debridement documentation gap between physician practice and inpatient coding, and help hospitals fare better when they bill MS-DRGs and appeal MS-DRG denials, Christiano says.

Physicians use CPT codes to bill for procedures and every year they are updated — revised, added and deleted — by the American Medical Assn., which publishes the CPT coding book. For example, CPT debridement skin codes 11040 and 11041 were deleted effective for services provided on or after Jan. 1, 2011, says Cynthia Swanson, senior manager of health care consulting for Seim Johnson in Omaha. CPT apparently wanted to alleviate the confusion around descriptions of partial thickness or full thickness of the skin and emphasize the depth of the debridement (i.e., the extensiveness or complexity of debridement depth that physicians must perform).

At the same time, CPT codes 11010 to 11012 have been revised to describe debridement somewhat differently. They include removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement), skin and subcutaneous tissues, muscle fascia, muscle and bone.

“The depth of the debridement determines the code selection,” Swanson says. To code CPT 11010, physicians must debride to at least the level of skin and subcutaneous tissue. If the depth of the debridement reaches the skin, subcutaneous tissue, muscle fascia and muscle, physicians report CPT 11011. And CPT 11012 includes skin, subcutaneous tissue, muscle fascia, muscle and bone. “Medical record documentation should support the location of injury and depth of debridement performed to coincide with the code selection,” she notes.

**Without Extra Step, MDs Paid for Wound Care**

CPT debridement codes 11042 to 11044 have been revised by surface area and depth, Swanson says. The depth has been further split into four levels of wound surface (epidermis/dermis, subcutaneous tissue, muscle, and bone). There are also new “add-on” codes — 11045 to 11047 — that are used to elaborate on more extensive debridement, she says.

Compliance officers and RAC coordinators should examine the modifications to the CPT code book. For one thing, it’s important for hospital-employed physicians to bill debridement accurately. But the CPT revisions also will improve compliance with MS-DRG debridement billing, according to Christiano.
“These CPT changes can only help hospitals,” Christiano says. “There was nothing in the CPT world to say that when physicians debrided the skin ulcer, they must specify excisional in the same way that inpatient documentation must specify.” With CPT before, if physicians said they debrided the skin and their notes indicated it was surgical — with a scalpel or other surgical instrument — they were paid for debridement, a surgical service, he says.

But CPT has deleted that code — 11040 — and now physicians must debride the skin and subcutaneous tissue to get paid for surgical debridement. If they don’t take that extra step, physicians are paid only for wound care, which is a loss if they truly debrided a wound. Wound care is usually performed by nurses and physical therapists, and is reimbursed at a much lower rate, Christiano notes.

Once physicians are accustomed to the more specific documentation required by CPT and their own claims are more accurately documented, hospitals should have an easier time supporting their claims for excisional debridement, which have been under attack since the days of the RAC demonstration, he says.

For example, with the new CPT codes, documentation will be deemed insufficient if physicians document they debrided a skin ulcer when in fact they went down to fascia or muscle using a #15 blade and the patient was given anesthesia. In this case, physicians will get paid only $88. But when physicians make it clear the excision went all the way down to fascia, muscle and bone, they will get paid $228.71. It’s not that physicians have to necessarily use the term “excisional” for deeper debridements (i.e., beyond skin and subcutaneous tissue), Christiano says. “It is this idea of it being of a surgical nature that helps the hospital,” and an excisional service is implicit in the description of the service. “If the doctor says debridement of fascia, the word excisional is assumed by ICD indexing,” he says. Similarly, “once you debride the bone, it is by definition excisional.”

The term “excisional” is not necessary when you debride bone, fascia or muscle; it is assumed by virtue of the procedure. That distinction should help hospitals fend off RAC and MAC claims denials and MS-DRG downcoding by Medicare quality improvement organizations, Christiano says. “The documentation has to be more specific for physicians to be paid appropriately and by extension that should help hospitals.”

RACS are now scrutinizing hospital claims for excisional-related MS-DRGs, including wound debridement for injuries with and without complications and comorbidities (CCs) or major CCs, and skin graft and/or debridement for skin ulcer or cellulitis with or without CCs and major CCs.

Hospitals Use Templates to Defend Claims

Hospitals are defending their claims, and one aggressive response is the use of separate templates for bedside debridement, Christiano says. With RACs and other auditors and reviewers challenging the validity of surgical procedures performed at bedside, hospitals may want to arm themselves with documentation to ensure physicians check off the hallmarks of an excisional debridement: the size of the wound; the depth of the debridement; whether anesthesia was administered; the instrument used (e.g., scalpel, scissors); and the nature of the tissue removed (e.g., necrosis, devitalized tissue).

“They are requiring physicians to fill these forms out because then documentation is incontrovertible,” he says. Physicians can use these “brief-op notes” if they ever are challenged by auditors in retrospective audits, Christiano says.
Denials and Appeals

Calif. Hospital Appeals RAC Decision in Federal Court

A California hospital is continuing its appeal of a recovery audit contractor (RAC) decision on two fronts in federal district court.

Palomar Medical Center filed a motion to stay in the suit it brought in 2009 against HHS while it attempts to obtain documents from the agency through the Freedom of Information Act (FOIA), which it originally asked for in 2008. In 2007, the RAC reopened a claim for almost $8,000 paid to Palomar in 2005.

The facility says the RAC never asserted “good cause” for reopening the claim. The RAC retroactively denied the claim in July 2007. Palomar appealed, but a fiscal intermediary and qualified independent contractor (QIC) affirmed the RAC finding. Palomar continued its appeal, eventually filing suit in the U.S. District Court for the Southern District of California in May 2009.

The court asked for a report and recommendation from a magistrate, who found that a provider can challenge the substantive portion of a RAC decision, but not the reopening of a claim.

Palomar objected to the report and maintains that the RAC did not have good cause to reopen the claim. It has filed a separate suit under FOIA to obtain the documents.

Update: August 2010

A federal court says that providers cannot appeal a recovery audit contractor’s (RAC) decision to reopen a claim, according to court records from the U.S. District Court for the Southern District of California.

A magistrate reported to the court that a provider can challenge the substantive portion of a RAC decision, but not the reopening of a claim. In an order released July 28, 2010, the court agreed with the report and noted that two regulations say the decision to reopen a claim is not subject to appeal.

The court denied Palomar’s motion for summary judgment with prejudice. ♦

RACs Throw Wrench in Hospital Audits Over ‘Retroqueries’ Despite AHIMA Approval

At least two recovery audit contractors (RACs) are denying hospital claims because some physician documentation was obtained through retrospective queries, even though CMS has generally approved the use of queries, sources said in summer 2010.

HealthDataInsights (HDI), the RAC for Region D, and Connolly Healthcare, the RAC for Region C, apparently consider retrospective queries an unacceptable form of information-gathering even though RACs put generic “physician queries” on the list of documents that hospitals must produce for audits.
“I don’t see how RACs can possibly deny them,” says Jonathan Eastabrooks, audit contractor program liaison for Franciscan Health System in Washington state. “How else are you going to seek out clarification” from physicians about a patient’s diagnosis and treatment when it’s not nailed down during the hospitalization? And, Eastabrooks notes, retrospective queries are recognized by the American Health Information Management Assn. (AHIMA).

One of the hospitals in Eastabrooks’ health system has been fighting an uphill battle with HDI over a claims denial that was based on a “retroquery,” as he calls it. The claim was for excisional debridement, a procedure to remove dead tissue. RACs will deny excisional debridement claims unless surgeons specifically document the term “excisional.” If they just say they used a sharp knife to remove necrotic tissue, for example, RACs will downgrade the claim to regular debridement, which pays much less.

Franciscan felt it had a legitimate excisional debridement claim, but the surgeon failed to use the word excisional. So a coder queried the physician after the claim was submitted, which is one definition of a “retrospective query.” HDI slapped the claim with an overpayment determination. Franciscan tried the discussion period route, which lets hospitals try to persuade the RAC it’s wrong before going the formal appeal route. But HDI turned a deaf ear because, it explained, “medical record documentation in the operative report indicated nonviable tissue was sharply debrided, however the narrative neither described the debridement as excisional nor indicated a surgical removal/cutting away of tissue. The physician was not queried for clarification of the debridement procedure prior to coding and submission of the claim for reimbursement; thus the determination is upheld.”

In response, Franciscan got the formal appeal process rolling in what’s called a redetermination. The case is now pending before Noridian Administrative Services, the fiscal intermediary for Washington state.

There’s no justification for the RACs to deny claims “with compliant and appropriate retrospective queries,” says query expert Andrew Rothschild, M.D., of Navigant Consulting. “This is such a big deal,” he says. “The whole concept that the RAC seems to have the ability to make and benefit from its own rules is not logical. They are making policies that are more restrictive than CMS’s.”

Connie Leonard, CMS’s director of the Division of Recovery Audit Operations, tells AIS that “the RACs have to follow the Program Integrity Manual Section 3.4.1.4 regarding late documentation. While the RAC usually needs to accept [a retrospective query], the RAC does have discretion concerning the weight given to the late documentation,” she says.

**CMS Defers to Industry Experts**

In fact, CMS stated in a 2001 memo (PRO 2001-13) that it “defers the promulgation of specific guidelines addressing these practices to health information management experts and organizations,” which is widely considered to refer to AHIMA. CMS notes that it “allows the use of the physician query form to the extent it provides clarification and is consistent with other medical record documentation” — as long as queries don’t ask physicians leading questions or introduce new information into the medical record. In 2008 query guidance, AHIMA explains that physician queries may be concurrent or retrospective.

Concurrent queries are done in real time, when patients are still in the hospital and documentation is under way, Rothschild says. Retrospective queries are initiated after discharge,
either pre-billing or post-billing. Hospitals use pre-billing queries to clarify information before the bill has dropped; post-billing means the hospital has submitted the claim but needs to make corrections. “It’s very important to have a clear-cut reason to query retrospectively,” he says. Hospitals don’t want to look like they are madly documenting ad-hoc to collect an extra fifty grand.

So why are RACs denying claims based on retrospective queries? Maybe, Rothschild says, RACs are seizing on a decade-old CMS statement (since rescinded) to Medicare peer-review organizations (now called quality improvement organizations). CMS told PROs that retrospective queries could not be used in audits. But CMS backed off after the industry made a compelling case for their necessity, he says, and issued the 2001 PRO memo. Retrospective queries are essential, Rothschild says, because sometimes there is a physician documentation omission or commission that coders must clarify. For example, he recently had to seek after-the-fact diagnostic documentation at a hospital-client to ensure the medical record was complete. Physicians treating a patient with leukemia thought he also had acute appendicitis, so they removed the organ and discharged him before the pathology report on the appendix tissue came back as normal. Because the patient was already gone but the discharge diagnosis — acute appendicitis — was wrong, Rothschild had to use a retrospective query to get treating physicians to correct the diagnosis. They disagreed among themselves, and the chart will probably state “abdominal pain, possible enteritis.” Billing for appendicitis would have been fraudulent, Rothschild says.

But he says hospitals must ensure they have a sound basis for retrospective querying. “Everything must be based on facts from within the current record,” he says. Don’t ask leading questions or base queries on information not otherwise in the medical record.

### Addenda May Trigger Denials, but ALJs Are More Tolerant as Long as Notes Are Kosher

Hospitals experiencing claims denials because of addenda have a good shot at restoring their payments when they make it near the top of the appellate food chain, experts say. Recovery audit contractors (RACs), for example, may be prickly about the use of addenda, but HHS administrative law judges (ALJs) seem more willing to look at the bigger picture.

The compliant use of addenda — which are supplements to a completed medical record — help protect an organization’s reimbursement. There is no Medicare prohibition on the use of addenda or dictates on how quickly they must be added to the chart, says attorney Lourdes Martinez, with Garfunkel Wild in Great Neck, N.Y. But some experts frown on addenda that are put in long after a patient’s discharge.

Meanwhile, some hospitals are expressing frustration that RACs are denying claims over their use of addenda and retrospective queries.

Ellen Scott, director of appeals management for Health/ROI, a consulting firm in Lake Success, N.Y., said in late summer 2010 that 87% of the RAC claims denials her firm has appealed for hospitals were overturned by administrative law judges. Appeals to ALJs were stronger when supported by physician addenda or medical-record clarifications, she says. “The ALJs
agree, as we were able to overturn more than 95% of appeals at the ALJ when they were
backed by medical record support, retrospective or not,” Scott says.

In one of Health/ROI’s cases, the demonstration RAC for New York denied a hospital claim
for excisional debridement because the physician clarified the nature of the debridement in an
addendum three years after performing it. Debridement is the removal of infected, necrotic
tissue, either excisional (ICD-9-CM 86.22), which is a surgical procedure performed by a physi-
cian, or nonexcisional (ICD 86.28), a nonoperative brushing, scrubbing or washing away of
dead tissue performed by a physician or nonphysician. Excisional debridement may affect the
MS-DRG assignment, triggering more reimbursement, so it has been a target of the RACs.

The claims denial involved the care of a 71-year-old patient, who presented at the hospi-
tal in 2004 after she fell and couldn’t get up. She had a history of hypertension, diabetes and
coronary artery disease, and had undergone a coronary artery bypass graft. But the patient’s
surgical wound hadn’t healed, and she had a chronic leg ulcer. After a work-up, the prin-
cipal diagnosis of syncope was confirmed, which required monitoring, and her wounds were
debrided. The medical record stated the patient received “daily local wound care with sharp
debridement of necrotic margins,” according to the RAC.

RAC Needed More Documentation

The hospital’s Medicare claim reflected coding for excisional debridement. But the RAC
(Connolly Consulting) disagreed, saying, “there is no documentation to substantiate that
an excisional debridement was done.” Instead, the documentation only supports billing for
nonexcisional debridement, which isn’t a surgical procedure, the RAC said. It relied on Coding
Clinic, the American Hospital Assn. coding newsletter, which states that “unless the attending
physician documents in the medical record that excisional debridement was performed…de-
bridement of the skin should be coded to 86.28, non-excisional.” As a result, in 2006 the RAC
downcoded the DRG from 076 to 085 to reflect the change from excisional to nonexcisional
debridement.

In February 2007, at the hospital’s request, the physician, a podiatrist, reviewed the benefi-
ciary’s chart. The podiatrist then provided the following addendum: “excisional sharp de-
bridement of LE skin ulcers.”

The hospital appealed the RAC denial, requesting a “redetermination,” which is handled
by Medicare administrative contractors (or fiscal intermediaries). In this case, National Gov-
ernment Services (NGS) in June 2007 denied the appeal, also citing Coding Clinic. “Unless the
attending physician documents in the medical record that excisional debridement was per-
formed (definite cutting away) or if it is described in the medical record as debridement and
no other information is available, debridement of the skin should be coded to 86.28, non-exci-
sional,” NGS said.

Up the chain the appeal went, with the next stop being “reconsideration.” Maximus Federal
Services, CMS’s “qualified independent contractor” (QIC), dealt the hospital its next blow. In a
2008 decision, Maximus stated that “there must be an adequate description of the wound, i.e.,
specific measurement and specific character; and also there must be an adequate description of
the sharp instrumental procedural process performed.” Because all these characteristics
were absent from the hospital’s claim, Maximus said, it supported the RAC’s downcoding.
Then it was the ALJ’s time to weigh in. The tide turned in favor of the hospital, which won back its full DRG payment. In his ruling, the ALJ repeated some of Scott’s testimony. She testified that *Coding Clinic* doesn’t require one specific note to capture all information requested for the code. Instead, Scott testified, a description of the wound and the actual recording of the procedure don’t have to be part of the exact same note as long as both exist in the medical record. “Further, she testified that in the past physicians thought of ‘sharp’ and ‘excisional’ as synonymous,” the ALJ noted. But recently, he said, *Coding Clinic* stopped treating the terms as interchangeable, a change some physicians are unaware of.

In the case on appeal, the ALJ said, the physician first described the procedure as sharp debridement and then changed it to excisional debridement. Because the medical records indicate a physician performed an excisional sharp debridement on the patient, “the evidence and testimony support the services at the level originally billed,” the ALJ proclaimed.

**Appeals Are Expensive and May Not Be Worth It**

While the victory is sweet, it also may be pyrrhic: Appeals are expensive and may cost more than the face value of the claim. “This process is so illogical [that] how could it be the intent of the statute or CMS?” says Robert Jacobs, president of Health/ROI.

Jacobs notes that when hospitals seek addenda, they are not necessarily asking physicians to remember the patient specifically. Instead, “you are asking them to clarify their own medical records.” He has obtained a legal opinion confirming the appropriateness of delayed addenda in limited circumstances where the physician is being asked to interpret and clarify the existing data in the record and not add new facts. But at least two of the permanent national RACs are refusing to accept information (i.e., addenda) obtained through retrospective queries. It remains to be seen how Medicare administrative contractors will react to addenda.

Scott cautions that retrospective addenda can’t be used in all circumstances. In fact, addenda entered more than a few days after discharge “should only be used in very focused instances,” she says. “Such addenda should only be clarifications of documentation already existing in the medical record and should be relegated to specific issues, such as the definition of the term ‘sharp’ as a synonym of ‘excisional’ to describe a debridement procedure.”

In the RAC appeal that was overturned by the ALJ, for example, the treating physician reviewed prior documentation without prompting and concluded the procedure was consistent with *Coding Clinic* advice, Scott says.

Here are tips for reducing the risks of addenda being rejected by Medicare auditors:

- **Don’t query in a leading way when asking physicians for addenda.** For example, don’t ask “yes” or “no” questions or ask specific clinical questions that direct the physician toward a particular answer.
- **Physicians must actually put information in the addendum, not just sign someone else’s note or say “OK.”**
- **Physicians should date the addendum on the day they are actually writing it.** No backdating.
- **Addenda can reference only specific supporting documentation that is already in the body of the medical record.** It can’t be new information not supported by the patient’s chart.
- **There’s no concrete answer to how long after physicians have seen the patient they can write an addendum.** If it’s years later, auditors may be skeptical the physician remembers the patient or
the encounter unless there was something outstanding about it. And states may regulate addenda. For example, New York State Department of Health regulations require hospital medical records to be complete within 30 days of discharge.

But don’t expect magic at the ALJ level. “It’s been my experience that if you take it to the ALJ but you have lousy documentation, you won’t be able to change it,” Martinez says. “But if the hospital feels it has decent documentation and the RAC is wrong, there is a good chance of winning at the ALJ level.”

Kathryn DeVault, manager of professional practice resources at AHIMA, “struggles with” the idea of addenda and retrospective queries done months or years after patients are discharged. “There is a big difference between one to seven days after discharge and one to seven months after discharge,” she says. From an auditor’s perspective, there would be suspicion that the hospital is trying to leverage more DRG reimbursement.

DeVault urges hospitals to think beyond RACs “because RACs will do what they want to do.” Instead, think from a compliance perspective. Define your policy and process for managing retrospective reviews and don’t deviate. If your hospital identifies five charts out of 500 that could have been billed at a higher level but it’s past the time frame for retrospective queries according to hospital policy, then instead use them as a training tool. Don’t give in to the temptation to seek a higher-weighted DRG. However, if you identify overpayments, obviously, there is no choice but to return them. ♦

Some Hospitals Are Able to Reverse Unfair Denials During The RAC Discussion Period

The RAC discussion period is turning out well for some hospitals, allowing them to stop Medicare recoupment without joining the appeals circus. But the 41-day discussion period, which was created by CMS in 2009, requires hospitals to move fast and may not be as effective with challenges to medical necessity denials as it is with DRG validations.

WellSpan Health in York, Pa., recently convinced the RAC to restore full payment for MS-DRGs in 12 of 20 disputed cases involving complex medical reviews. Most of the overpayment determinations stemmed from the RAC downcoding MS-DRGs by rejecting the complication/comorbidity (CC) or major CC (MCC). WellSpan, however, found that its documentation generally supported the higher-paying MS-DRGs, and the RAC ultimately agreed during the discussion period.

“RACs make mistakes just like we do,” says Colleen Dailey, clinical coordinator of defense audits for Well-Span, which had submitted a total of 300 medical records to the RAC as of November 2010.

The discussion period was designed to give providers a chance to change the RAC’s mind before heading down the formal appeals route. Providers submit additional medical records to support their claim, point out documentation that the RAC overlooked, or set the RAC straight on misapplied Medicare or coding rules.

The discussion period kicks in after providers receive a “review results letter,” which explains the outcome of the RAC audit. It ends when the RAC sends a Medicare administrative contractor-approved demand letter specifying the dollar amount that the provider owes
Medicare from the overpayments identified in the review results letter. Providers have 41 days in between to make their case for a denied or downcoded claim. “Why not do it? It’s a window of opportunity,” Dailey says.

**RACs Think Discussion Period Is Effective**

CMS has no hard data on the use of the discussion period, says Connie Leonard, director of the Division of Recovery Audit Operations. But “I think the RACs feel that the discussion period is effective for getting additional information, if all was not submitted with the request, and is certainly beneficial to keeping unnecessary appeals from occurring.” It works best for complex reviews, Leonard tells AIS. “For automated reviews, the provider is not learning of the improper payment until the demand letter comes. At that time, it is best for the provider to appeal.”

WellSpan used the discussion period to thwart “a large reduction in revenue” for MS-DRG 438 (disorders of the pancreas except malignancy with an MCC), Dailey says. The dispute stemmed from the role the patient’s HIV infection played in his diagnosis. The man was admitted to the hospital through the emergency department (ED) after presenting with acute abdominal pain and elevated lipase. A CT scan confirmed pancreatitis and the ED physician documented a diagnosis of “pancreatitis, cholangitis” (liver disease). Other documentation in the chart backed this up, Dailey says. For example, in the history and physical, the treating physician cited the patient’s “acute renal failure secondary to pancreatitis and cholangitis.”

An infectious disease consult stated that “pancreatitis is due to the HIV medications” and the surgery consult said the “cause of the pancreatitis is not immediately clear. Impression is pancreatitis of undetermined etiology.” The discharge summary concluded that the patient had “pancreatitis probably from his HIV medications. Acute renal failure.”

Based on the documentation, the coder assigned diagnosis codes that grouped to MS-DRG 438, with the HIV infection for the MCC. But the RAC — Diversified Collection Services (DCS) — downcoded the claim to MS-DRG 977 (HIV infection).

Dailey fought back because the RAC’s reclassification didn’t make sense. “All of the documentation in the medical record supports that this patient’s pancreatitis is due to his HIV medications,” she told the RAC. “The documentation does not state the pancreatitis is from the patient’s HIV disease. Pancreatitis is not an HIV-related condition. The patient’s HIV was never treated except to discontinue the medication used to treat the HIV.”

The RAC didn’t have to take her word for it. According to *Coding Clinic* (fourth quarter 1994), if a patient with HIV disease is admitted for an unrelated condition, the code for the unrelated condition should be the principal diagnosis. She also pointed the RAC to the November/December 1984 edition of *Coding Clinic*, which says that an adverse effect occurs when a drug is correctly prescribed and properly administered. Coders should code the reaction to the drug and the appropriate code to identify the drug (from the E930 – E949 series). In the WellSpan case, pancreatitis is the reaction to the HIV medications, Dailey says. The RAC agreed with Dailey’s arguments and changed its mind, so WellSpan will receive reimbursement for the higher-paying DRG.

Consultant Donna Wilson, who works with multiple hospitals across the country, has also seen hospitals use the discussion period to reverse coding denials, saving the expense and hassle of an appeal. But she says her hospital clients are frustrated at the reasons they have to
invoke the discussion period: mistakes RAC auditors make because they haven’t yet grasped the basics of hospital coding.

“If you show RACs that you have coded it the right way according to Coding Clinic,” you will be successful, says Wilson, who is a senior director with Compliance Concepts, Inc. She advises hospitals to be explicit when explaining the support for their claims (i.e., turn to page 25 in the Coding Clinic index). Although the discussion period has turned out to be a useful tool, Wilson says coding professionals “feel like they are teaching the RACs how to code.” Some RAC reviewers are certified professional coders (CPCs), which means they are physician practice-oriented, instead of certified coding specialists (CCSs), who are typically inpatient-oriented. “They aren’t as savvy at hospital coding. We shouldn’t have to teach them Coding 101. That’s one of the frustrations.” But it explains why hospitals “are going through discussion periods and they are winning,” Wilson says.

Clarify Handwriting in Discussions

Sometimes hospitals need the discussion period just to clear up misunderstandings, Wilson says. For example, one RAC was reviewing the medical record for an excisional debridement patient treated by a physician with bad handwriting. The physician had written “bleeding bed,” which is part of the documentation for excisional debridement. But the RAC thought the chart said “bleeding bone,” which is another code and a different MS-DRG, Wilson says. When the RAC downcoded the MS-DRG, the hospital used the discussion period to explain the physician had a legibility problem, and that dictation would verify the existence of “bleeding bed.” In response, the RAC reversed the downcoding and granted the hospital full payment. “They were reasonable in this case,” Wilson says. “They were not dinging for legibility.”

The RAC sometimes downcodes MS-DRGs despite the presence of legitimate CCs or MCCs, Dailey says. That has been a theme of RACs and RAC-like auditors used by other payers. For example, WellSpan had to defend a claim for a cerebral infarction patient with a secondary diagnosis of acute respiratory failure (MS-DRG 64). The 88-year-old woman had such a massive stroke that she went into a very deep coma. Her air had to be protected, which required intubation. The RAC said the documentation didn’t support the code for the secondary diagnosis of acute respiratory failure (ICD-9-CM 518.81) and downgraded the MS-DRG to 66 (intracranial hemorrhage or cerebral infarction without CC or MCC).

But when Dailey looked at the medical records, it seemed almost absurd the RAC would drop the secondary diagnosis. The patient was in bad shape and, in addition to being unresponsive on arrival, scored three out of 15 on the Glasgow neurological scale. Dailey looked in the Merck Manual, which said that patients who have a Glasgow scale of less than eight, low oxygen saturation and shallow respiration require endotracheal intubation. And if they require endotracheal intubation, by definition they are in acute respiratory failure, says Dailey, a former critical-care nurse who also serves as clinical documentation improvement specialist at WellSpan’s Gettysburg Hospital.

The RAC agreed, WellSpan kept its higher reimbursement and another appeal was averted.

Adapt the CMS Discussion Letter

To streamline the discussion period, Dailey adapted CMS’s discussion letter template for her own use. That way, she submits the same form every time she asks the RAC to open a discussion period. After downloading the CMS letter to her laptop, Dailey added text fields for
the hospital name, its national provider identifier (NPI), its tax identification number, whether it’s a complex audit, the patient information and the reason for not agreeing with the RAC’s overpayment determination. “I have done that for all levels of appeals,” Dailey says.

For example, the RAC downgraded a WellSpan claim for MS-DRG 329, small and large bowel procedures with an MCC, which in this case was nutritional marasmus (severe malnutrition). The RAC was willing to pay for DRG 330, the same procedure with CC (diverticulitis), which resulted in less reimbursement. It’s natural for auditors to be skeptical of nutritional marasmus because it’s rare in developed countries, says Dailey. But support for coding marasmus was in plain sight. The patient weighed 64 pounds and had a body mass index (BMI) of 15 (less than 19 is considered malnutrition with supportive data, Dailey says). She had lost 22 pounds and had received intravenous Albumin, a protein for malnourished people. “I picked out the indications of wasting,” she says. “I highlighted all the buzz words that would lead a person to believe the patient was malnourished. The RAC accepted the MCC,” so WellSpan won back the greater DRG reimbursement.

Discussion Period Is Not for Everyone

Hospitals may have a different experience when the discussion period is used to dispute a claims denial based on lack of medical necessity. One of Wilson’s hospital clients used the discussion period to address the RAC’s site-of-service change of a short-stay admission for a patient with syncope and anorexia. “The medical director said, ‘We are not saying your patient did not need to be in the hospital. We are saying the patient did not need to be at the inpatient level of care. The level of care for observation would have been more appropriate,’” Wilson said. “Without either cardiac/neurological cause or failed outpatient intervention in recurrent situations, which results in a new diagnosis and likely a different DRG, this type of inpatient admission is difficult to defend.” Wilson urges hospitals to hammer away at admission diagnoses that are unlikely to warrant inpatient care.

And not everyone uses the RAC discussion period. For example, it isn’t of much consequence to Franciscan Health System in Washington state. While Franciscan has used the period successfully for denials from automated reviews when the RAC made a “clear-cut” error, 41 days is not long enough to analyze the RAC’s accuracy in complex reviews “because we are overburdened,” says Jonathan Eastabrooks, audit contractor program liaison. “Everything else would have to be shelved.”

When the RAC is wrong, Franciscan will rely on the regular appeal process, Eastabrooks says, with its 120-day deadline. “Our philosophy is, we can always appeal and we have 120 days to do it, so why [struggle] to meet the 41-day deadline?” he says. Eastabrooks is the one who prepares the paperwork, whether it’s a discussion period or appeal, so he figures it’s six of one, half a dozen of another.

RAC Misinterprets Basic Coding Rule, Raising Questions About Knowledge Level

Hospitals should be on the lookout for claims denials by auditors who are misapplying basic Medicare rules. If an auditor’s errors are identified quickly, hospitals may be able to avoid appealing claims denials, although that’s not always the case.
WellSpan Health in York, Pa., experienced the frustration of a recovery audit contractor (RAC) error, and is being forced to appeal, says Wendy Trout, director of corporate compliance and revenue management. Its RAC, Diversified Collection Services (DCS), sent WellSpan the results of its first automated audit, which involves black-and-white errors, such as billing more units of a service or drug than allowed by Medicare. Automated audits don’t require medical-record reviews.

In this case, DCS’s “demand letter” asserted that WellSpan owed money for errors detected by “correct coding edits” (formerly called “comprehensive/component codes”). Correct coding edits are part of CMS’s National Correct Coding Initiative (NCCI), better known as the Correct Coding Initiative (CCI). The CCI was implemented to control inappropriate coding that causes Medicare overpayments, according to the CMS website. There are different kinds of CCI edits. For example, correct coding edits apply to code combinations where one is a component of a more comprehensive code and shouldn’t be billed separately. Mutually exclusive code edits include codes for services that can’t be performed in the same session. CCI edits are part of the outpatient code editor (OCE), which screens all outpatient claims and assigns APCs for outpatient services.

The problem with the RAC’s overpayment finding, Trout said in January 2011, is it applied CCI edits before they took effect. As CMS notes on its website, CCI tables are updated quarterly, and the edits in the OCE “are always one quarter behind the physician edits.” When the RAC audited a batch of WellSpan claims, it applied the physician CCI edits in effect as of Oct. 1, 2007. But the edits were not relevant for hospitals until Jan. 1, 2008. Apparently, the RAC failed to grasp a fundamental Medicare coding rule: Hospital CCI edits are always applied one quarter after physician’s CCI edits. For example, the RAC denied a WellSpan claim on the grounds that it included codes 93356 (a CCI column one code) and 75600 (a CCI column two code); 75600 is a component of 93356 and shouldn’t be billed separately. But the claim reflected services provided on Oct. 25, 2007, before the edit was applicable to hospitals, Trout says.

It irked Trout to think that it would be her burden to straighten out a problem created by the RAC’s lack of knowledge about CCI edits, so she complained to the CMS project officers for her RAC. As she wrote in an e-mail to CMS, “Can you address this issue so that facilities do not have to appeal claims that should not have been denied in the first place?”

**CMS Was of No Assistance**

Her effort was in vain. CMS referred Trout back to the RAC and its informal discussion period. The RAC took down her information but never followed through. Trout is mounting a formal appeal — not because the money at stake in the claims denials amounts to much, but to stop the RAC from continuing to misinterpret the CCI edit rule.

“It concerns me. Some facilities don’t have resources to really dig into these things and may be losing money every time one of these edits comes up with a quarterly delay,” Trout says. Hospitals may figure that automated reviews are so straightforward that no internal oversight is necessary. But obviously, that’s not always the case.

The message: “Don’t just assume your automated results are accurate. You might think it’s not worth wasting your time with automated audits because [RACs] don’t even look at medical records, but there are things to fight.” ☞
Hospitals Waste Valuable Resources Fighting Unfounded Denials by RACs

Some compliance officers continue to fight denials from recovery audit contractors (RACs) that they say defy logic, and are frustrated with the lack of feedback from RACs that hospitals could use to improve their claims submissions.

The tension is over automated reviews, which target black-and-white errors, such as billing more units of a service or drug than allowed by Medicare. They are driven by claims data analysis alone, and don’t require medical-record reviews.

Compliance officers at different hospitals in February 2011 described recent struggles they have had with Diversified Collection Services (DCS), the RAC for 12 states (e.g., Pennsylvania, New York and New Jersey). The problems range from the RAC wasting a hospital’s time with audits that don’t meet CMS guidelines to denials of claims that lacked modifier 59 because of a technical mistake overlooked by the Medicare administrative contractor (MAC).

“I am not against auditing, but it should not be punitive,” says a New York state hospital compliance officer, who declined to be identified. “It takes a lot of resources to gather documentation to send to [the RAC] when the issue was billed correctly in the first place and it’s not an overpayment.”

For example, DCS recently denied seven hospital claims submitted by WellSpan Health of York, Pa., says Wendy Trout, director of compliance and revenue management. Trout determined that the denials were unjustified and fought back. When she called to check the status of the claims, DCS told her that WellSpan’s money would be returned because the claims were outside the CMS-approved three-year audit timeframe, Trout says. In other words, the audit should never have happened. RACs have an audit “look-back” period of three years, and can’t go farther back than October 2007. DCS told her that the look-back window is based on the date of payment, not the date of service or claims submission, which was an eye-opener. The majority of this batch of denials stems from claims submitted in October 2007, but they weren’t paid until January 2008. That’s more than three years before the date of the RAC “demand letter,” which informs hospitals they owe money based on automated reviews. DCS told Trout that the date of payment triggers the clock on the three-year deadline. “What matters is the date of payment,” Trout notes. “I never realized that.”

But there’s more to the story. DCS initially denied the claims erroneously by applying Correct Coding Initiative (CCI) edits before they had taken effect, Trout says. The RAC violated a fundamental Medicare coding rule, but neither CMS nor DCS seemed responsive to Trout’s complaints. WellSpan returned the “overpayment” pending appeal, consistent with its policy of avoiding interest charges while the two sides wrangle over the merits of a claims denial. WellSpan fully expected to get the money back when it won the appeal on the grounds that claims can’t be denied because the RAC has retroactively applied CCI edits. When she checked in with the RAC, Trout learned that all of the sound and fury were unnecessary. DCS had cancelled its overpayment demands because the claims were outside the three-year look back period. “The kicker is, if I hadn’t called, I wouldn’t have known about this mistake,” Trout says. “I wonder when they were going to tell me that.”
RAC Mistakes Are Costly to COs

There are still some unresolved claims denials around the look-back issue. “They might be inside the window by just a hair,” Trout says. For example, one claim was paid on Dec. 28, 2007, and the RAC demand letter was dated Dec. 28, 2010 — exactly three years later. “I guess they are allowed,” but Trout wants to confirm it. Meanwhile, DCS still has denied one claim based on the CCI edit, so she continues to fight that.

Trout is not alone. The compliance officer at the hospital in New York state has had her frustration tolerance level challenged by the RAC, which is also DCS. In addition to denials she thinks are wrong on their face, the compliance officer says the RAC provides no opportunity to learn from the outcome of the audit, “positive or negative,” and therefore providers don’t improve their billing, which is a stated CMS goal of program-integrity contractors.

The New York hospital has had a series of denials that make no sense and prompted the compliance officer to question the integrity of the RAC’s data:

(1) The RAC denied claims for services that were missing modifier 59. The modifier tells Medicare it’s appropriate to pay for two procedures performed on the same patient on the same day because they were significant and separately identifiable. Without modifier 59, the MAC’s CCI edit is supposed to automatically deny the claim. But that didn’t happen, and the claims were paid. The compliance officer says this should not be fodder for the RAC because it’s a technical glitch, not an overpayment, a position supported by Trout, who says that Well-Span had a claims denial for the same reason. Normally when hospitals fail to append modifier 59, MACs deny the claim with an explanation, allowing hospitals to rebill properly for two significant, separately identifiable services that were provided and appropriate, the New York compliance officer says. But when the MACs drop the ball and pay the hospital anyway, there is no substantive error because the hospital provided two significant, separately identifiable services, backed by documentation, and deserves the money, both compliance officers say. “They are hanging denials on a technicality because we didn’t bypass the edit, but the payer paid because the service was provided,” the compliance officer says. “A provider can bill for two services in a CCI code pair and apply the modifier on a claim to bypass the edit and allow the FI to reimburse for both services.”

(2) Many automated reviews target billing for more units for a service than allowed by Medicare. The compliance officer says DCS has denied such claims for therapy (e.g., speech, physical). “The RAC stated in their letter that we have an aberrant billing pattern inconsistent with the CMS manual, but when I went to review these, it was not incorrect,” she says. The hospital charged one unit of therapy according to the HCPCS codes. “My question is, if their data analysis is telling us it is an inconsistent billing pattern but we find it’s correct, what is going on?” It throws all of the RAC automated reviews into question, she says.

Ultimately, DCS overturned all of the claims denials at issue here. But not before the compliance officer, a one-woman show at a large hospital, invested a lot of time in deciphering the RAC’s problems with the claims, investigating whether the hospital did anything wrong and then fighting back in a discussion period, which must be done within 15 days of receiving the demand letter.

RAC demand letters don’t explain which line item on a claim is allegedly wrong. The RAC gives the patient name and date of service(s), but it’s not enough information to easily identify which service is targeted. “We have to go to the remittance advice to find out which line item
the RAC denied,” the compliance officer states. She goes back into the patient accounting system and works with the billing department just to pinpoint the denied codes. “It would work better if they tell us the service by code, the amount [of money] and the date of service,” she says. “That would help us track back to the service they are questioning so we can get documentation.”

The compliance officer says she isn’t resistant to external auditors. But it’s been a disappointment that the RAC gives no feedback so hospitals can improve their coding and billing. Even after the RAC discussion period, the RAC doesn’t explain the reasoning behind its decision to uphold a payment denial. Hospitals only receive a form letter listing many possible reasons, which has no value for preventing future errors.

Marie Casey, deputy director of CMS’s audit division, says she is aware of “recent problems” with approved RAC audits in Region A, which is DCS’s territory. “However, once the problems were identified, DCS immediately sought clarifying instructions from CMS and has issued rescind letters to correct the problems,” Casey tells AIS.

**Hospitals Start Getting Medical-Necessity Denials From RACs**

Recovery audit contractors (RACs) are beginning to deny Medicare claims on the grounds that they lack medical necessity.

“We are seeing a lot of medical necessity short-stay denials in surgical and medical target areas,” says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia.

In the medical arena, hospital one-day stays have been denied for transient ischemic attack (TIA), syncope, chest pain, and patients with gastroenteritis, dehydration and diarrhea, he says.

In the surgical arena, hospital one-day stays have been denied for cardiac stents, orthopedic procedures (e.g., laminectomies), and some urological procedures (e.g., urethral swings for incontinence). And RACs have denied some dialysis access procedures performed in an inpatient setting, Taylor said in March 2011.

What these site-of-service denials often have in common, Taylor says, is the discharge of inpatients before they stay overnight in the hospital. According to the Medicare Benefit Policy Manual, the rule of thumb for most inpatient admissions is that the physician expects the patient to stay in the hospital overnight and occupy a bed. Some of the claims denied by the RACs stem from services that could have been provided in observation or should have been outpatient procedures. “If the patient is at relatively low risk of short-term morbidity and/or death, and the doctor never has any expectation of keeping him overnight, outpatient care may usually be more appropriate,” Taylor says. In other cases, physicians may have hospitalized high-risk patients with the intent of keeping them overnight, but the patients fared well and could be sent home earlier. Denials in those circumstances may often be successfully appealed.

To prevent unwarranted admissions, Taylor suggests hospitals review admission necessity concurrently — while the patient is still in the hospital — and be very precise about it.
For example, with laminectomy, the details of the case may determine whether admission is necessary for this expensive procedure for a particular patient. A laminectomy is a spine operation in which a piece of bone is removed, usually to treat abnormal narrowing of the spinal column. In recent years, some types of laminectomies have become much less invasive. As a result, they may be performed in the outpatient setting. Because RACs are targeting inpatient laminectomies where the patient goes home the same day, hospitals should carefully screen them for medical necessity of the appropriate setting, Taylor says. “Not all laminectomies are the same,” he emphasizes. Laminectomies are defensible as an inpatient procedure, Taylor says, under certain circumstances:

◆ **Patients undergo more extensive procedures (i.e., more bone is removed).**

◆ **There is the potential for complications,** such as uncontrolled pain requiring higher frequency and doses of intravenous analgesic medications or greater than expected blood loss.

◆ **Patients have certain comorbidities,** such as uncontrolled diabetes, or in some cases ASA class IV patients with significant systemic diseases may need to be admitted.

But if an attending physician mistakenly believes that all laminectomies should always be performed in the inpatient setting, and the hospital case manager doesn’t check to ensure that the procedure fulfills the Medicare medical necessity requirements, “an overpayment could occur,” Taylor says. Even if admission screening tools (e.g., InterQual, Milliman) give the green light for admission, that isn’t a guarantee of Medicare coverage, a position CMS has made abundantly clear. ◆