RACs: Proven Tips and Tactics to Reduce Your Audit Risks and Appeal Payment Denials

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Introduction

CMS funding for recovery audit contractors has almost doubled for fiscal year 2012, with the investment in RACs rising from $259 million in 2011 to $500 million. That’s a sign that RACs likely will recoup more money from providers, since RACs are paid only when they identify Medicare errors that survive provider appeals.

Since CMS launched the 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.

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. Among key targets:

- Urinary procedures and kidney conditions;
- Septicemia;
- The post-acute care transfer (PACT) rule;
- Respiratory failure;
- Place-of-service errors;
- Syncope; and
- Gastrointestinal bleeding.

You’ll also learn about strategies hospitals can use to steer clear of payment pitfalls, from drilling down into billing data from CMS’s Program to Evaluate Payment Patterns Electronic Report (PEPPER) to improving physician documentation. And amid all the focus on the common risk areas, hospitals also should not lose sight of the importance of conducting self-audits of their organizations to catch errors.

We welcome your comments, suggestions and additional information for future editions of this report. Please send them to our book editor, Erin Trompeter, at etrompeter@aishealth.com. Thanks for your help in keeping us up to date with the rapidly changing landscape of RAC audits.

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CMS Initiatives and Guidance

CMS Switches Gears, Approves RAC Audits During Blackout Periods

Some hospitals in spring 2011 were facing RAC audits during their transition to a Medicare administrative contractor (MAC), although CMS previously froze RAC audits during “blackout periods.” CMS is apparently doing an about-face on blackouts, noting that RACs have been around a long time and that hospitals should be able to cope.

This development has some compliance officers worried; they wonder whether CMS will change other rules of the RAC game.

Blackout periods were intended to alleviate confusion during CMS’s consolidation of fiscal intermediaries (FIs) and carriers into MACs. In 2009, CMS said providers would get a RAC audit reprieve if a new vendor won the MAC contract and had to take the claims-processing reins from outgoing Part A and Part B contractors. A CMS spokesman told AIS at the time that the blackout period “is three months before a MAC cut-over date and three months after the MAC cut-over date.” CMS also addressed this issue on its website with answers to frequently asked questions (FAQs). For example, RACs may audit the type of claims (e.g., Part A) if the MAC vendor already had the region’s Part A (FI) business and just took on Part B (carrier) in the new MAC contract.

But CMS has changed its tune, according to Susan Parker, corporate compliance officer for Ephrata Community Hospital in Ephrata, Pa., and Carol Wise, the hospital’s external audit coordinator. In April 11, 2011, emails obtained by AIS, Scott Wakefield, CMS project officer for RAC regions A and B, said that RACs can request medical records during the blackout period and that CMS can shorten the blackout period. “Because the blackout period is a contractual provision developed for the CMS National RAC Program and not a federal regulatory requirement, CMS has the discretion to alter the approach used for this process.” That’s the case for all four RAC regions, he noted.

Wakefield explained that “changes could be made to the blackout period to lessen the impact of the transitions on the RACs” because of the “progressive working relationship between the RACs and MACs.” For example, he said, the “timeframe for the blackout period may be altered at CMS’s discretion (e.g., the timeframe may be shortened if CMS deems this action appropriate).”

He noted, however, that RACs still can’t trigger overpayment recoupment during the blackout period, which means providers won’t see cash flow affected by claims denials until the lights are back on.

Ephrata Community Hospital is still in the blackout period, but suddenly it’s on the receiving end of RAC medical-record requests, Parker and Wise say. They understood that if their RAC had started an audit before the blackout period began, it could continue. But CMS had said that no new RAC automated or complex reviews could begin when the blackout switch was flipped.
Ephrata’s Part A claims used to be processed by Wisconsin Physician Services (WPS), which was the FI for that part of Pennsylvania. On Feb. 21, 2011, the Part A and Part B claims processing for the region were switched to Highmark Medicare Services, which won the MAC contract. Highmark was already Ephrata’s carrier but now it became its full-service claims processor, triggering the blackout period for Part A claims. Parker and Wise say that, consistent with previous CMS statements, there should be no RAC activity in the region until May 21, 2011, which is 90 days after Feb. 21, 2011. But in an April 5, 2011, mailing, Ephrata received 26 letters requesting 116 medical records, Parker says. That’s the first time the RAC requested records from the hospital.

**RAC Knew Nothing of Blackout Periods**

Baffled, Wise contacted DCS and spoke to a customer-service representative, who never heard of the blackout period. She faxed the blackout information to DCS, including explanations of the blackout period from Medicare contractors. A few days later, the DCS customer service rep said that Wakefield had informed the RAC that medical records can be requested during blackouts.

Although Ephrata is prepared to deal with RAC audits, Parker and Wise say that isn’t the point. They expect CMS to keep its word. “My concern is, if CMS can change this because it’s contractual, they can just change anything,” Wise says. “Providers need consistency from CMS in order to build efficient audit response processes. If it is not defined in the [RAC] scope of work, we are vulnerable to having to make large adjustments to seemingly minor changes, such as the time frames for medical records submission.”

Parker says hospitals should be prepared for the RACs, even if they think they have time because of the blackout period. “We didn’t wait to get our first request to set up our process,” she says. “We have a software application to track this.” Wakefield wrote in his email much the same thing when essentially asserting the blackout periods are elastic. “The program has now been active for well over two years,” he said.

**CMS: Sending Records Electronically Will Make Audits More Bearable**

CMS is launching an online platform that will allow providers to electronically submit paperwork to the contractors that perform claim reviews. The process could be completely electronic for certain providers as early as October 2012, according to a CMS official. CMS made this move because it realizes how arduous, time-consuming and expensive it is for providers to submit documentation to Medicare auditors for claims review the old-fashioned way, the official said at an Aug. 24, 2011, provider outreach session.

Medicare contractors that perform medical review and audits — including Medicare administrative contractors (MACs), recovery audit contractors (RACs) and the Comprehensive Error Rate Testing (CERT) contractor — sent out around 2 million documentation requests in 2010, said Melanie Combs-Dyer, deputy director of the Provider Compliance Group in the Office of Financial Management.

When providers get the request letter from a contractor, they have the choice of mailing the paper records, mailing a CD with the records stored on it or faxing the records back to the con-
tractor, Combs-Dyer said. “This is particularly frustrating in situations where the provider has an electronic health record. They end up having to print out their electronic medical records [i.e., EHRs], put it in a box and send it to the review contractor,” she said. Even worse, the contractor often takes those paper records and scans them into its system to send PDFs to the nurse-reviewers. “How inefficient can we be?” Combs-Dyer asked.

“Our solution to this problem is Electronic Submission of Medical Documentation (esMD),” she said. The program will roll out in two stages:

♦ **Phase I, effective in September 2011, will still involve paper.** The contractors will still send a letter through the mail to the provider, but the provider will be able to submit the requested documents electronically.

♦ **Phase II may be operational by October 2012, CMS hopes.** It will allow contractors to electronically send their documentation requests to providers with providers responding in kind.

Combs-Dyer stressed that participation in esMD is not mandatory for providers and likely never will be. “CMS recognizes that not all providers are adopting health IT solutions at the same pace,” she said. “A number of providers fall into the category that I would consider a late adopter....They don’t need to worry about esMD; they can stick with their paper.” But early adopters of EHRs are eager to start using the system. “They recognize what a cost savings this is going to be for them, and they are ready to sign up now,” she said. The providers that don’t enter Phase II will continue to receive letters requesting documentation from the contractors, she noted.

The esMD program will be linked to the Nationwide Health Information Network. It’s made up of NHIN Exchange (which connects agencies and providers for information exchange) and NHIN Direct (a secure email system), Combs-Dyer explained. Providers will need a gateway to access NHIN and participate in esMD. Although some large providers could create their own gateway software, many will likely hire firms Combs-Dyer referred to as health information handlers to provide those services. A facility’s EHR vendor also could link them to the NHIN, as well as to Health Information Exchanges or Regional Health Information Organizations.

CMS hopes eventually that esMD users will be able to view outbound documentation requests, the status of claims and appeals information, administrative transactions (e.g., eligibility look-up), claims submission, refund submission and “anything else that you currently send to Medicare or Medicaid in a paper [form],” Combs-Dyer said.

There are numerous benefits of esMD, according to Combs-Dyer. “A number of providers have told us for many years that they would love to have an electronic way to send medical documentation to Medicare,” she said. “They believe it would be a cost savings to them...when they will no longer have to hire someone to key in all those medical records that are being requested in each of those request letters that comes every 45 days from the [RAC] or periodically from the [MAC].” But it may not be worthwhile for providers who get only a few documentation requests from contractors.

Durable medical equipment (DME) suppliers also can use esMD, which could streamline the process when auditors ask them for documentation, Combs-Dyer pointed out. A DME supplier using esMD as well as NHIN Direct could communicate with physicians via NHIN Direct to ask for and receive records from the doctor’s office. “So they would be able to send the secure email to the doctor to say, ‘I got a documentation request from RAC C. Could you
send me the medical documentation for Patient 123?’ And when that comes back through secure email to the DME supplier, they could then forward that information on to the [health information handler], who could forward it on to the review contractor who requested it” via esMD, she said.

**CMS Nearly Doubles Investment in RACs, Has Method to Win More Provider Appeals**

CMS funding for recovery audit contractors (RACs) will almost double in fiscal year 2012, which was set to start Oct. 1, 2011. The investment in RACs will rise from $259 million in 2011 to $500 million, a sign they will recoup more of the green stuff from providers because RACs are paid only when they identify Medicare errors that survive provider appeals, according to former RAC executive Vickie Axsom-Brown.

And RACs — which CMS now calls “recovery auditors” — are not the only Medicare auditors armed with generous budgets and new overpayment-recovery strategies.

“Each year the amount spent on recovery audit activities is going to increase because they will find more improper payments and as improper payments go up, the value of the findings will go up,” Axsom-Brown said at a Sept. 8, 2011, webinar sponsored by RACMonitor.com. Also on CMS’s 2012 agenda: better success fending off provider appeals of RAC claims denials. One of the agency’s “performance targets” for 2011-2012 is a reduction of RAC overpayment determinations thrown out on appeal, said Axsom-Brown, former regional vice president of HealthDataInsights, the RAC for Region D. As of March 9, 2010, providers won 64.4% of the appeals they filed — although they only challenged 76,073 of the RACs’ 598,238 overpayment determinations. Now RACs may get a boost in fending off provider appeals from the validation contractor, which CMS hired as a check and balance when the national RAC program got underway. Every month, the validation contractor reviews 100 RAC claims denials (per recovery auditor) for accuracy and outcomes. Results from the validation contractor can be used to support RAC defenses when providers appeal overpayment determinations, she noted. But the overriding goal is to improve RAC performance over time, which is in everyone’s best interest, said Axsom-Brown, who is now president of Audits & Recovery Solutions in Henderson, Nev.

Connie Leonard, director of the CMS Division of Recovery Audit Operations, tells AIS that CMS is pleased with the results of the validation contractor’s findings. The accuracy rates are high, she says, although she couldn’t be more specific. Results will be released soon in a report to Congress.

Recovery auditors also may pile on audit targets faster than ever. CMS is required to approve “issues” (e.g., DRG validations, short stays) before RACs can audit providers in these areas, and they must persuade CMS with preliminary reviews that the audits won’t be a waste of hospital resources. But because the process can be slow, in June 2011 “CMS asked the four RACs to collaborate on common issues so approval could be expedited,” according to Axsom-Brown. That went well, she said, and as a result “CMS will ask them to collaborate on more issues.”

RACs are far from the only type of auditor intensifying scrutiny of hospitals and other providers. Axsom-Brown listed six others: the medical review units at Medicare administrative
contractors (MACs); zone program integrity contractors, known as ZPICs; Medicaid RACs; Medicaid integrity contractors (MICs); quality improvement organizations (QIOs); and the HHS Office of Inspector General.

**Review Materials Posted by RACs**

It is important to keep an eye on the material posted by MACs, because they are major program-integrity players and they produce reports for CMS that are good sources of compliance monitoring, she says.

For example, Noridian Administrative Services, the MAC for six states on the West Coast, on Sept. 1, 2011, started a review of surgical claims for percutaneous vertebroplasty and percutaneous vertebral augmentation (kyphoplasty) involving CPT codes 22520 to 22525. “They are receiving claims that lack documentation to support the necessity and appropriateness of surgery. These claims will now be stopped and audited,” Axsom-Brown said.

There’s no secrecy about these kinds of medical reviews, which are based on data from OIG, RACs and the Comprehensive Error Rate Testing (CERT) contractor, she said. They are announced on MAC websites.

Also, two quarterly reports that MACs submit to CMS may be useful tools for compliance monitoring. One type of report addresses overpayments and how they were discovered. Every quarter, MACs have to trot out the number of claims attributed to overpayments according to their cause and break it down by dollar amount and means of discovery. The overpayment causes are:

- **Beneficiary not entitled.**
- **Services not covered.**
- **Charge exceeded reasonable charge.**
- **Payment made to wrong payee.**
- **Duplicate payment.**
- **Medically unnecessary services.**
- **Services not rendered.**
- **Medicare secondary payer.**
- **Documentation/coding/data entry.**
- **Other.**

MACs also report how overpayments were discovered:

- **Reported by beneficiary or supplier.**
- **CMS’s carrier quality control program.**
- **Carrier internal audit or review.**
- **Government agency.**
- **Other methods of discovery.**

Another MAC report concerns beneficiary overpayments. Axsom-Brown said MACs are required to report details of beneficiary overpayments. If providers are overpaid, then beneficiaries are paid more than their fair share (e.g., a 20% copay of a $1,000 claim is obviously more than 20% of a $500 claim).
“CMS is collecting all this data and using it to give feedback on where improper payments are coming from and how they can be stopped,” Axsom-Brown said. “Hospitals need to look at these sites to figure out what is in the pipeline and what is being executed now. This is proactive,” and it’s much more effective to audit for overpayment risks early than to wait for OIG auditors or ZPIC investigators to appear at your door.

**QIOs Are a Major Force**

QIOs are also a force to be reckoned with. Their latest CMS contract with QIOs — April’s statement of work — includes more improper payment activities. In addition to quality reviews, QIOs review potential EMTALA violations, adverse events, DRG upcoding, higher-weighted DRGs, short stays and readmissions, among other things, she said.

Because the odds are high that some of your claims will be targeted by these auditors at one time or another, preparing for claims-denial disputes is essential, Axsom-Brown said.

She provided guidelines to help providers develop their own checklist for complex audits for “any kind of audit you might get” (e.g., RAC, MAC). Hospitals should tailor their checklists to the topic. If it’s a short-stay audit, for example, look at how OIG and other Medicare agencies approach short stays. And checklists should be developed keeping in mind the people in your organization who will actually carry out the audit, she said.

Here are key audit steps:

1. **Nail down the purpose of the audit** based on the external auditor’s medical record requests.
2. **Gather information on the audit topic.** Check websites — including those for CMS, the RACs, OIG, the CERT and specialty associations — for updates on the target.
3. **Document information about the audit topic.** Use the information gathered as a foundation for your internal medical-record review, but make sure it’s sourced so the veracity can be evaluated. Look for common factors in the information.
4. **Pull requested medical records** and start an internal audit.
5. **Contact industry peers and evaluate** their experience with the audit topic (e.g., audit preparations, results and resources).
6. **Use the information to audit requested medical records and identify any problems.** “Managed care/billing teams should review both billing and medical record documentation for completeness, accuracy, medical-necessity support, documentation/billing errors (dates of services, place of service, providers), data matching and quality of care indicators,” Axsom-Brown said. Incorporate items from MAC medical-review checklists.
7. **Identify issues.** Figure out whether there’s a problem. Will claims be denied? If so, how many? Will they be full or partial denials? Have you opened a can of worms with the internal audit, and found far more serious problems? If you were unable to locate complete medical records during the internal audit, attach a letter with other supporting documentation that shows medical necessity and appropriateness of the health care delivery when the medical records are submitted to the external auditor, she said.
8. **Review medical-record submissions.** “Make sure all relevant documentation is included with the medical records” when they are submitted to the external auditor,” she says. Double check this by having a colleague review the document production and ask questions about it.
Axsom-Brown advises knowing the status of every medical record requested “so you know the likelihood of denials,” and the resulting cost of repayment, especially if the external auditor extrapolates the error rate based on a smaller sample. “That report is used to keep [your] manager and my board of directors apprised of the repercussions of the audit activity,” she said.

New RAC Statement of Work Gives and Takes; Less Burden Promised

In the future, recovery audit contractors (RACs) may focus a bit less on hospitals and a bit more on other provider types, and look harder for underpayments.

At least that seems to be the message that CMS has sent to RACs, according to their new statement of work, which spells out RACs’ job duties through February 2014.

“If CMS has evidence to believe a recovery auditor is not reviewing all claim/provider types, CMS will issue an official warning to the recovery auditor,” the statement of work says. “If the lack of reviews continues, CMS will consider recalling specific claim/provider type(s) from one recovery auditor and giving the opportunity to review the claims/providers to another CMS contractor.” The statement of work also emphasizes RACs’ contractual obligation to find underpayments, which is listed as the very first task.

“This is a message that the RACs are supposed to look across a broad spectrum of claims,” says Atlanta attorney Sara Kay Wheeler, with King & Spalding.

There are a number of changes in the new statement of work, which is now in effect. “There are interesting things that cut both ways in terms of giving a little more flexibility to the RACs and adding protections that providers can lean on to hold RACs’ feet to the fire,” Wheeler says.

Here are highlights of the new RAC statement of work:

♦ **RACs are required to develop procedures** to minimize the burden on providers when identifying over-payments. It’s not just “something advocates are trying to persuade them to do,” Wheeler says. Giving providers some breathing room is now a RAC marching order.

♦ **CMS formalized a new type of RAC audit**, the semi-automated review. This two-part review combines aspects of automatic and complex reviews. “This type of review is to be used in which a clear CMS policy does not exist but in most instances the items and services as billed would be clinically unlikely or not consistent with evidence-based medical literature,” according to the statement of work. RACs identify billing aberrations through automated reviews, and when there are “high indexes of suspicion to be an improper payment,” providers are invited to submit documentation to support their claims. RACs will deny the claims if providers don’t submit documentation or it doesn’t support the way the claim was billed. Providers aren’t entitled to reimbursement for sending in documentation during semi-automated reviews, the statement of work says.

♦ **RACs won’t get contingency fees** for their overpayment determinations unless they comply with CMS’s deadline for completing a review, which is 60 days after receiving the provider’s medical records (unless CMS grants an extension). Providers still must repay the Medicare money, but this is a big incentive for RACs to report audit conclusions promptly to providers, Wheeler says.
CMS added contractors to the RAC data warehouse. To ensure RACs don’t interfere with fraud investigations, RACs are required to enter all claims targeted for overpayment or underpayment action into the RAC data warehouse. “Updates in the statement of work expand the universe of entities that are authorized to input claims into the data warehouse for exclusion and suppression,” including zone program integrity contractors (ZPICs) and quality improvement organizations (QIOs), Wheeler says. Providers can request the exclusion or suppression of claims from RAC reviews when the claims are already under scrutiny by another contractor or enforcement agency or have been resolved through voluntary disclosure and refund.

CMS is now calling RACs the “recovery auditors.” This will affect how providers, attorneys and others research RACs in legal databases, in CMS publications and on websites.

The possibility of rebilling MS-DRG lack-of-medical necessity denials as outpatient services seems to exist, says Royal Oak, Mich., attorney Drew Wachler. There are a number of signs pointing this way in the statement of work, he says. For one thing, in discussing partial claims adjustments, CMS says RACs must downcode claims whenever possible. The statement of work cites as one example “inpatient stays that should have been billed as outpatient,” and states that “this includes some medical necessity claims.” And CMS notes that RACs will get a contingency fee only on the difference between the inpatient and outpatient claims, Wachler says.

Final Rule on Medicaid RACs Covers Fraud Referrals, Coordination

CMS’s final rule on the Medicaid recovery audit contractor (RAC) program, released Sept. 14, 2011, contains guidance for states on ensuring that RACs report fraud to state and federal officials, provider appeals, and coordination with other contractors and government agencies that are conducting audits.

The health reform law mandated that each state hire a RAC to review Medicaid claims for overpayments and underpayments. The contractors will receive a contingency fee for their findings, but CMS has said that this fee will be covered by the overpayments found.

CMS has always said that it would give states flexibility in how their programs are structured. But based on lessons learned from Medicare’s RAC program, the final rule makes strong suggestions in some areas. For example, because Medicare RACs referred only two cases of fraud to CMS between 2005 and 2008 despite identifying about $1 billion in overpayments, CMS says states should ensure that Medicaid RACs report any “reasonable grounds to believe that fraud and/or abuse had occurred.”

Medicaid RACs also will have to employ staff members trained as nurses, therapists, certified coders and physicians — another lesson learned from the Medicare version of the program.

CMS gave the states two suggestions for structuring their appeals processes:

(1) A state can use its existing appeals infrastructure to resolve appeals of Medicaid RAC findings, or

(2) A state can create a separate appeals process for RAC findings.

The final rule takes effect on Jan. 1, 2012.
In First RAC Report to Congress, CMS Says Contractor Validates RACs

In its first report to Congress on the national recovery audit contractor (RAC) program in fall 2011, CMS outlines where it’s been and where it’s going.

CMS describes the effectiveness of RACs in identifying and correcting Medicare payment errors through post-payment review for fiscal year 2010 (Oct. 1, 2009, to Sept. 30, 2010). At the end of that time period, the agency said RACs recovered $92 million for Medicare, after adjusting for underpayments that were returned to providers. The majority of RAC “corrections” — 82% — were overpayments, while the rest were underpayments.

“CMS knows it’s a good way to return dollars left on the table,” which is why Medicaid RACs will be similar to Medicare RACs, says former RAC executive Vickie Axsom-Brown, now a consultant with BHM Healthcare Solutions in Henderson, Nev. The report also discusses the RAC expansion to Medicare Parts C and D.

The four RACs were rated on the quality and outcomes of their audits as assessed by CMS’s validation contractor. Here are their scores:

◆ **Diversified Consulting Services (Region A):** 98.6
◆ **CGI (Region B):** 99.2
◆ **Connolly (Region C):** 97.6
◆ **HealthDataInsights (Region D):** 99.4

Connie Leonard, CMS’s director of the Division of Recovery Audit Operations, told AIS in September 2011 that “the rates are high, and CMS is pleased with them.”

CMS described the categories of errors that led to the most significant recoveries. They are listed below in order of the total dollars identified in error (before accounting for underpayments), according to the report, which covers a time period before medical-necessity reviews had caught fire:

◆ **RAC Region A:** Incorrect code ($3,171,808); unbundling ($563,485); noncovered, nonallowed and other services ($382,015); medically unnecessary items or services ($276,736); and incorrect discharge status ($157,192).
◆ **RAC Region B:** Incorrect number of units ($9,606,678); incorrect code ($4,159,492); incorrect Medicare service provider billed ($398,050); unbundling ($90,742); and incorrect discharge status code ($60,770).
◆ **RAC Region C:** Incorrect code ($18,164,294); incorrect number of units ($3,219,533); unbundling ($2,787,660); noncovered, nonallowed, other services ($44,024); and multiple error code values within claim ($5,567).
◆ **RAC Region D:** Unbundling ($11,835,149); incorrect code ($5,598,794); noncovered, nonallowed, other services ($2,764,816); incorrect number of units ($2,366,098); and incorrect discharge status ($1,772,106).

The report also cites a number of system improvements under the national RAC program. For one thing, CMS implemented a “mass adjustment system,” which leads to more automated adjustment of providers’ accounts when MACs giveth and taketh away in response to overpayments and underpayments identified by the RACs.
In addition, the report explains what’s going on with the RAC data warehouse. It is used to generate reports on the types of claims that auditors focus on and that generate more bang for the buck. The warehouse contains data about all claims under RAC review, and other program-integrity contractors, such as MACs and zone program integrity contractors (ZPICs), are supposed to check it before launching a review. “The Data Warehouse is used by CMS to ensure that Recovery Auditors do not review claims previously subjected to medical record review by another review entity, such as a claims processing contractor, or that are currently under review by law enforcement,” the report states.

The improvements to the data warehouse described by CMS in the report should relieve some of the audit burden on providers, says Axsom-Brown, former regional vice president at HealthDataInsights. Sometimes RACs pull claims from the common working file for one audit but may sit on them until the next audit cycle. The problem, she says, is that RACs may request medical records unless they revisit the warehouse to ensure these particular claims were not downloaded by another Medicare auditor in the meantime. “It creates a dual audit request to the same provider,” Axsom-Brown says. But the report indicates that “CMS is working to make things better,” she says, and the new RAC statement of work may help.

With Error Rates Remaining High, the RAC Prepayment Review Demo Returns Soon

CMS has hit the reset button on the recovery audit contractor (RAC) prepayment review demonstration, which will start “on or after June 1, 2012,” according to a Feb. 3, 2012, announcement on the agency’s website. CMS also will begin a second demonstration for power mobility devices that was postponed at the same time, but it has been “significantly revised.”

These initiatives, which are designed to reduce improper payments, were put on hold in late December 2011 in response to industry concerns. But they will be back in action soon, a reflection of CMS’s preference for techniques that prevent improper payments instead of chasing them after the fact.

Medicare administrative contractors (MACs) are conducting prepayment reviews on different risk areas around the country. But one former CMS official says prepayment reviews are too expensive to trigger a paradigm shift. Medicare processes a billion claims a year, “so they can’t do a significant percentage [of reviews] on a prepayment basis,” says Washington, D.C., attorney Don Romano, a former director of the CMS Division of Technical Payment Policy who is now with Foley & Lardner LLP. Instead, there will be targeted strikes in areas where there is reason to believe specific providers don’t understand billing requirements or are committing fraud.

The RAC prepayment demonstration will take place in 11 states: Pennsylvania, Ohio, North Carolina, Missouri, Florida, Michigan, California, Texas, New York, Louisiana and Illinois.

The demonstration for power mobility devices (e.g., power wheelchairs) has been revamped. It originally required prepayment review and prior authorization for power mobility devices in certain states, but CMS has eliminated prepayment review, among other changes it made.
Meanwhile, CMS has been moving ahead with a third demonstration, on Part A-to-Part B rebilling. That allows participating hospitals to resubmit claims for allowable Part B payment after an auditor has determined that the Medicare beneficiary met the requirements for Part B services but not for an inpatient stay. There are two catches: CMS only pays 90% of the Part B reimbursement for rebilled claims, and hospitals can’t appeal if they’re deemed ineligible under Part B. But rebilling is allowed for medical-necessity denials by RACs, Medicare administrative contractors and the comprehensive error rate testing (CERT) contractor. CMS will accept only 10% of the nation’s hospitals into the demonstration, and “I heard anecdotally that CMS got 380 applicants,” says Romano. Participating hospitals can quit the demo, but they can’t appeal claims rebilled under Part B, he says.

It’s no surprise these programs are back and that Medicare watchdogs will hammer away at payment errors from all angles. Of the 10 federal-government programs with the highest improper payment amounts in fiscal year 2011, four are Medicare and Medicaid, according to Feb. 7, 2012, testimony from Beryl Davis, director of financial management and assurance for the Government Accountability Office, who appeared before the House Committee on Oversight and Government Reform’s Subcommittee on Government Organization, Efficiency and Financial Management.

**Which Programs Ranked the Worst?**

Specifically:

- **Medicare fee-for-service won the top spot**, with $28.8 billion in improper payments, according to the GAO. That’s an 8.6% error rate, and the primary causes were medically unnecessary services and insufficient documentation.

- **Medicaid was number two on the ranking of improper payments** in all federal programs, accounting for $21.9 billion in overpayments, which is an 8.1% error rate. The primary cause was ineligible or indeterminate eligibility status of Medicaid beneficiaries.

- **Medicare Advantage came in fifth**, with $12.4 billion in improper payments, an 11% error rate. The main causes were insufficient documentation, and errors in the transfer and interpretation of data and payment calculations.

- **The Medicare prescription drug benefit program (Part D) was 10th**, with $1.7 billion in improper payments, a 3.2% error rate. The primary causes were payment errors, payment adjustment errors and the complexity of the program.

However, the GAO official said that some federal agencies reported progress in driving down error rates. “For fiscal year 2011, [Office of Management and Budget] reported that governmentwide agencies recaptured $1.25 billion in overpayments to contractors and vendors. Over half of this amount, $797 million, can be attributed to the Medicare recovery audit contractor program,” Davis said.

The government is now intensifying efforts to prevent improper payments, Davis says. Preventive controls include eligibility verification, predictive analytics, training programs, and timely resolution of audit findings. For example, before paying Medicare fee-for-service claims, CMS uses predictive analytic methodology to screen them, Davis said. This new “Fraud Detection System” has been in place nationally since June 30, 2011.
Given the error rates, the focus on program integrity won’t end anytime soon, says Brian Flood, a national managing director for KPMG. “There’s no silver bullet, but they have at least started giving the programs the necessary push from the top and finances to support the mission of collecting improper payments,” he says. The government has to continue to use technology, such as data mining and predictive modeling, in addition to human intervention (e.g., prepayment and postpayment reviews) to achieve the overpayment reductions set forth by President Obama and described in the GAO report, he says. 🖼
High-Risk and Target Areas

RAC Overpayment Identification Is Picking Up Steam; Hospitals Improve Oversight

CMS has collected $313 million in Medicare overpayments identified by recovery audit contractors under the national RAC program, according to an April 26, 2011, update. The agency also cites the top sources of overpayment recoupment, which include two MS-DRGs and durable medical equipment furnished to hospital patients.

Total collections between October 2009 and March 2011 are lower than the $992.7 million in overpayments identified by the RACs during the three-year demonstration (March 2005 to March 2008). However, RAC recoupments have skyrocketed in the first three months of 2011 compared with the previous year and a half.

The overall drop in overpayments “tells me that providers have improved coding, billing and documentation processes since the RAC demonstration project,” says Maryann O’Brien, director of corporate compliance for Erie County Medical Center in Buffalo, N.Y. “Providers have learned from previous mistakes. Edits put in place by [Medicare administrative contractors] or providers may have also caused a reduction in overpayments because the edit catches the mistake before the bill is submitted to the MAC or the MAC denies the claim.”

Conversely, Medicare underpayments that were detected by RACs and returned to providers have climbed, from $37.8 million during the demonstration to $52.6 million under the national program. But that number is still seen as understated because providers probably underbill Medicare more than that, says Susan Parker, corporate compliance officer for Ephrata Community Hospital in Ephrata, Pa. RACs that want to get their CMS contracts renewed probably can’t be too zealous about identifying underpayments, she says. The CMS update doesn’t include figures on claims denials that were appealed and won by providers.

The top overpayment issues cited by CMS didn’t come as a shock to compliance officers and RAC coordinators. The biggie for Diversified Collection Services (DCS), the Region A RAC, is ventilator support 96+ hours. Hospitals may have their claims denied because coders are misreading the time that patients are being ventilated, says Heidi Shirk, RAC program coordinator for Penn State Milton Hershey Medical Center in Hershey, Pa.

“Make sure that the coders are using the actual intubation and extubation times, according to the documentation,” she says. For example, if a patient was intubated at 13:00 on 04/06/2011 and extubated at 00:00 on 04/09/2011, coders should only account for 59 hours, and then assign the ICD-9-CM code for mechanical ventilation [less than]96 hours, Shirk says. That places the case in the appropriate MS-DRG — ventilator support [less than]96 hours — not the MS-DRG for ventilator support 96+ hours. “I believe some coders would see 04/06/2011 to 04/09/2011 and bill (code) for four whole days of vent support instead of the actual number of hours,” she says.
Hospitals Use Coding Quality Reviewer

To guard against RAC denials, Shirk sends RAC target areas to Hershey Medical Center’s quality assurance analyst as soon as they are posted on the DCS website. The QA analyst then double checks the charts for these risk areas before the bills are dropped. “We do this for all approved issues on the DCS website,” Shirk notes.

The top issue for CGI, the Region B RAC, is extensive operating room procedure unrelated to principal diagnosis. This series of MS-DRGs, which includes 981, 982, 983, 987 and 989, is under scrutiny around the nation. Hospitals bill for extensive OR procedures unrelated to principal diagnoses when patients have multiple conditions, and two could meet the definition of “principal diagnosis,” says Wendy Trout, director of compliance and revenue management at WellSpan Health in York, Pa. The principal diagnosis, which is the condition found after study to be chiefly responsible for occasioning the hospital admission, drives MS-DRG assignment. Coding guidelines allow coders to pick between two applicable principal diagnoses, but it’s a “subjective” process and the RAC may not agree that both conditions triggered admission, Trout says.

Faced with the prospect of RAC denials, WellSpan decided that one of its coding quality reviewers will review the coder’s selection of the principal diagnosis before these claims are

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<th>A Quick Update on RAC Recoveries and Targets</th>
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<td>CMS posted this information on the permanent recovery audit contractors (RACs) on April 26, 2011.</td>
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<tr>
<td>Demonstration</td>
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<td>Overpayments Collected</td>
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In accordance with Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS conducted a Recovery Audit demonstration from March 2005 to March 2008. The U.S Congress authorized the nationwide expansion of the Recovery Audit program through the Tax Relief and Health Care Act of 2006. Recovery Auditors are CMS contractors who are tasked with detecting and correcting past improper payments.

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<th>Top Issue per Recovery Auditor (National Recovery Audit Program: FY 2010–March 2011)</th>
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<td>Overpayment Issues</td>
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<td>Region A: Diversified Collection Services</td>
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submitted. “It’s still subjective, but at least two people agree before the bill goes out the door,” Trout says.

As for the other two RACs — Connolly (Region C) and HealthDataInsights (Region D) — the top overpayment issue is durable medical equipment, prosthetics and orthotics (DMEPOS) provided during an inpatient stay. Apparently, RACs have found significant problems with claims for DMEPOS that are submitted with a date of service after the patient’s discharge even though the patient got the DMEPOS while in the hospital. CMS has a “2-day rule” for DMEPOS provided to patients in anticipation of their discharge from hospitals or nursing facilities. Under the 2-day rule, a supplier may deliver the item to hospital patients to fit them or train them in the proper use of the item up to two days before their anticipated discharge. The supplier then bills the date of service on the claim as the date of discharge and lists the place of service as the patient’s home. But suppliers can’t bill for DMEPOS items used by the patient prior to the patient’s discharge from the hospital. Medicare doesn’t allow separate billing for surgical dressings, urological supplies, or ostomy supplies provided in the hospital because reimbursement for them is wrapped into the Part A payment. This prohibition applies even if the item is worn home by the patient when leaving the hospital. A supplier may, however, deliver an item to a patient’s home in anticipation of a discharge from a hospital — as early as two days before the anticipated discharge (see the Program Integrity Manual, Chapter 4, Section 4.26.2).

In another RAC development, Connie Leonard, director of recovery audit operations at CMS, tells AIS that “currently there is no cap on semi-automated reviews.” CMS recently announced that RACs would do a third kind of review — semi-automated reviews — in addition to automated and complex reviews. With semi-automated reviews, RACs send hospitals a notification letter describing a billing aberration with a “high index of suspicion to be an improper payment,” and hospitals must submit medical records if they want to prevent recoupment.

But it’s been unclear until now whether there is a limit on how many semi-automated reviews a hospital can face at a time. There’s no ceiling at the moment, but, Leonard says, “CMS will certainly keep an eye on the volume of semi-automated reviews. Since CMS controls the approvals of issues, we feel we can monitor the impact. There is no timetable, so semi-automated reviews can be done at any time.” Providers still have 45 days to submit documentation to rebut the RAC’s assertion of an overpayment.

**Scrutiny of Medical Necessity Intensifies, but Gray Areas Persist**

Expensive procedures that are covered only if they meet specific Medicare coverage guidelines face greater scrutiny from recovery audit contractors (RACs) and other watchdogs. Instead of challenging the medical necessity of the inpatient admission for the procedure, reviewers in spring 2011 were questioning the medical necessity of the procedure itself. “RACs have been looking at the correct setting of care, but we have seen increasing focus recently from auditors and investigators on whether a procedure is necessary in the first place,” says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia.
A prime example is cardiac procedures — stents, pacemakers and automatic implantable cardiac defibrillators (AICDs). They’re all high-volume, high-dollar procedures, and reimbursement hinges on compliance with national coverage decisions (NCDs), which describe the conditions of coverage. Only certain procedures are subject to NCDs (or local coverage decisions), which means Medicare won’t pay unless patients meet explicit criteria. That makes the job of auditors and investigators easier; they are questioning whether the patient needed the cardiac procedure at all based on the NCD, which is obviously a different question than whether it should have been implanted in the outpatient setting instead of the inpatient setting. “There is an abundance of clinical evidence about which patients benefit from these procedures, so investigators have good reason to believe they should focus on them,” Taylor says.

**National Inquiry by DOJ Is Underway**

The Department of Justice (DOJ) has a national investigation underway of AICD surgery at hospitals and cardiac stents are a target area of CMS’s Program to Evaluate Payment Error Patterns Electronic Report, or PEPPER. And St. Joseph Medical Center in Towson, Md., paid $22 million in November 2010 to settle false claims allegations over kickbacks and Stark violations involving a group of cardiac surgeons and to reimburse Medicare for payments it received “for medically unnecessary stents performed by Mark Midei, M.D.,” according to the U.S. attorney’s office for the District of Maryland. The hospital fired Midei and yanked his privileges.

Physicians and hospitals should expect claims denials unless the reason for performing the procedure comports with the NCD’s coverage indications. It may happen more often than you think because clinical literature and evidence continue to evolve, Taylor says. “The physician may follow clinical guidelines, but be unfamiliar with the NCD,” he says. If they conflict, Medicare will deny the claim.

Documentation is a big problem. When physicians don’t explain how patients meet the NCD’s coverage guidelines, they are asking for trouble with auditors. Pacemakers are a classic example, Taylor says. The Comprehensive Error Rate Testing (CERT) program has identified pacemakers as an area rife with errors. The specific vulnerability is dual-chamber pacemakers, he says. In its NCD (20.8), CMS distinguishes the coverage requirements for single-chamber versus dual-chamber pacemakers. For example, the NCD states that patients are eligible for dual-chamber pacemakers when (1) they have single-chamber pacemakers and a definite drop in blood pressure; (2) they have “pacemaker syndrome,” which means their atrial and ventricle chambers are not beating together and it’s causing significant symptoms; (3) pacemaker syndrome can be anticipated; or (4) a small increase in cardiac efficiency will improve their quality of life.

**Physicians Must Document the Rationale**

Physicians, however, often fail to document the reasons for a dual-chamber pacemaker — and, specifically, to explain why it’s medically necessary to implant a dual-chamber pacemaker instead of the cheaper single-chamber version, Taylor says. The claim may be denied unless the medical records fully explain the reason for the dual-chamber pacemaker, he says. Auditors tend to examine everything in the hospital record — admission notes, discharge notes, procedure notes — and claims may be denied if pieces of the documentation puzzle...
were left in the physician’s office. “Make documentation easy to find and document specifically how the NCD is fulfilled,” he says. “Be very specific why dual chamber is necessary.”

Also make sure patients receiving the device don’t have one of the exclusions in the NCD. That disqualifies them from coverage, which again may trigger a claims denial, he notes.

Hospitals are at particularly high risk with AICDs because of the double whammy of Medicare auditors and the DOJ investigation. The NCD for AICDs (20.4) has nine coverage indications, and the common denominator is timing of the device placement, Taylor says. “Physicians need to be aware of timing when they perform the procedures,” he says.

There are two groups of indicators:

1. **Secondary Prevention:** AICDs are medically necessary for patients who already suffered life-threatening arrhythmia (indicators one and two on the NCD).

2. **Primary Prevention:** AICDs are medically necessary for patients who have not yet experienced life-threatening arrhythmia, but who are at risk for various reasons. For example, they may have coronary artery disease with prior heart disease or inducible sustained arrhythmia on an electrophysiology study. But many of these patients are not eligible for AICDs if they had a myocardial infarction within the previous 40 days or if they had a bypass or PTCA (stent) within the previous three months.

**Explicit, Thorough Documentation Is Needed**

Documentation for AICDs must be explicit and thorough, Taylor says. “Make it clear to the auditor that it was necessary and appropriate. If auditors have to hunt through hundreds of documents, the procedure may be denied,” he says. And don’t force auditors to use a decoder ring to translate what you’re thinking. “If ejection fraction is necessary, the doctor should make sure an accurate ejection fraction is on the [hospital] record and not just in their office record.”

The NCD for stents (20.7) requires physicians to establish objective evidence of myocardial ischemia. According to the NCD, “the lesions [in arteries] should be amenable to angioplasty and the procedure should be performed for angina refractory to optimal medical management.” Hospitals may see denials in some cases if previous medical management is not documented. Physicians should document the medical management that has been tried with patients before resorting to surgery. Explain what was effective, what wasn’t and why. A detailed explanation of why angioplasty is necessary should be provided, he says.

To minimize denials for all cardiac procedures, Taylor says, hospital case management should use a two-pronged approach: education and screening. Make sure physicians are well-versed in the NCDs. It’s helpful to have access to templates and other tools that make it easier to determine if patients meet the NCD standards. “Some hospitals are finding they can improve the process with an abstraction tool that case management can use,” he says.

Hospitals should differentiate the clear-cut from the gray-area cases, because some cases will require more analysis before surgery proceeds, perhaps from physicians with particular expertise in the area who can help determine if documentation of coverage requirements is sufficient, Taylor says. For example, CMS recognizes that experts may differ in their judgments about what constitutes appropriate criteria for dual-chamber pacemaker use. Similarly,
with AICDs, these physicians might not always agree whether the NCD has been satisfied in a given case.

Auditor attention to NCDs fits in with the overall “paradigm shift” in health care, Taylor says. Payers increasingly expect physicians to follow evidence-based guidelines and auditors will increasingly review based on them. “There will be more accountability,” he notes.

Meanwhile, as the DOJ investigation of AICD implantation at hospitals continues, they are finding that medical necessity is not as cut and dried as expected, says one attorney with clients targeted by DOJ. The hospitals have asked DOJ to remove ambiguous cases from the review, says the attorney, who asked not to be identified. Some hospitals may be dropped from the probe altogether. “The level of dialogue has been constructive,” he says.

One of his clients did an internal audit and found that most cases met the NCD criteria for AICDs; only eight required further review. “The upshot is, this may be less about liability and more about medicine,” the lawyer says.

Kidney Injury, Urinary Surgery Are Targets as RACs Amp Up Medical-Necessity Reviews

Some hospital claims for urinary procedures and kidney conditions are going up in smoke as recovery audit contractors (RACs) challenge admission necessity and/or coding accuracy. In particular, RACs are targeting acute kidney injury, as well as certain procedures such as transurethral resection of the prostate and cryoablation of bladder, kidney, prostate and other tumors.

Hospitals are appealing many of the denials on the grounds that it’s easier said than done to send home patients who are old and sick with multiple conditions. But physician documentation may not be doing hospitals any favors.

“It is often hard to tell from existing documentation whether or not the patient is actually sick, let alone sick enough to warrant an admission. It may be that the patient was an appropriate admission, but the physician’s documentation doesn’t reflect diagnostic terms that illustrate the patient’s condition and the physician’s level of concern,” says physician Andrew Rothschild, who is a director with FTI Healthcare in Austin, Texas.

For example, Diversified Collection Services, the RAC for Region A, recently denied 143 claims for one-day stays submitted by WellSpan Health on the grounds the patients didn’t require inpatient care, says Colleen Dailey, clinical coordinator of defense audits. Some of these claims are for cryoablation and transurethral resection of the prostate. Dailey is preparing appeals because, she said in spring 2011, many of the cases were unfairly denied and the RAC did not review all relevant documentation.

In one case, an elderly patient needed cryoablation, in which probes are inserted into tumors to repeatedly freeze and thaw them, which kills the cells. Because the patient was obese, the surgeon did a dry run to ensure no organs would be punctured. The surgeon moved the thorax and liver out of the way to get to the kidney, and discovered he’d need to use three probes instead of two because of the tumor’s size. But still the RAC insisted the procedure could have been performed on an outpatient basis and denied the claim, Dailey says.
As part of the process of appealing denials for urinary procedures and kidney conditions, Dailey consulted with WellSpan’s nephrologist, who has helped her understand why the procedures were done on an inpatient basis when they tend to be done on outpatients. It turns out in 2008, when the procedures were performed in the disputed cases, cryoablation and transurethral resections were new to WellSpan. And, she notes, sometimes patients are high risk (e.g., they are on blood thinners, so there’s a potential for uncontrolled bleeding). Obviously, these are not young, healthy patients to begin with. “Age is one reason they should be inpatient; plus it was a brand new procedure at the time,” Dailey says. “They decided to err on the side of caution.” She thinks the RAC is making rash decisions partly because they don’t look at the entire medical record, which often supports admissions. Instead, RACs review only history and physical (H&P) notes, Dailey contends.

Other experts in the field have confirmed that RACs have refused to recognize physician diagnoses unless they’re in the H&P.

Penn State Milton S. Hershey Medical Center in Hershey, Pa., also is starting to experience RAC medical-necessity denials for one- and two-day stays and a lot are urology related, said RAC Program Coordinator Heidi Shirk in spring 2011. The hospital is appealing a number of cases because its documentation “looks pretty good.” She notes that “these are older patients,” meaning they probably have comorbid conditions that put them at greater risk if they are treated on an outpatient basis. In one case denied by the RAC, a 74-year-old patient had a history of bladder cancer and other comorbid conditions. After the tumor recurred, the patient was admitted for transurethral resection of the tumor, a procedure to remove it. The RAC denied the claim, saying the admission was not medically necessary. She says short stays just seem to trigger denial. “But there are so many other factors in this case that should have been taken into consideration,” Shirk says.

When RACs deny inpatient admissions, hospitals are unable to convert the cases to APCs under the outpatient prospective payment system. But they have been told by CMS that they can charge Medicare for ancillary services, so at least they can recoup some of their costs since services were provided, albeit in the wrong setting according to the RACs.

Unfortunately, Shirk says that “rebilling” for ancillary services has come under fire, as at least one fiscal intermediary said that hospitals were beyond the timely filing deadline by the time the RAC denies the inpatient claim and therefore they can’t rebill for ancillaries. Finally, however, Shirk says the matter has been clarified. In a recent teleconference, Highmark Medicare Services said that hospitals are allowed to rebill for ancillary services related to denied inpatient admissions, she says. “We submit a 121 type of bill for ancillary charges along with a remark indicating this was a RAC denial for medical necessity,” Shirk says. “We also pay back the DRG payment via an immediate offset.”

Kidney Conditions Are Big for RACs

Admission for kidney failure or injury has attracted RAC scrutiny. This is both a DRG coding and an admission issue. “RACs are being very aggressive with it,” Dailey says.

WellSpan recently had acute renal failure MS-DRG claims denied from 2008/2009 on coding grounds. Physicians documented the presence of acute renal failure, but still RACs denied the claims. The diagnosis was based on WellSpan’s internal criteria. It requires a bump in creati-
nine, a lab test that measures kidney function, from 0.5 or 50% above the baseline. And both
the attending and consulting physicians agreed the patients had acute renal failure. “They are
denying it, saying we have no evidence to support it even though we have,” Dailey says. “It’s
escalating and not in a good way. They are making a medical judgment.”

Part of the problem, Dailey says, is there’s a lack of consensus about the definition of “acute
renal failure,” even among nephrologists. So far, Medicare has been unwilling to share its crite-
ria, despite requests from hospitals. “If Medicare would let us in on the ‘mystical’ documenta-
tion required, it wouldn’t be the dispute it is today,” Dailey says.

Renal failure’s state of flux causes havoc in the world of coding and medical necessity,
Rothschild says. The term “acute kidney injury” (AKI) was introduced as a more comprehen-
sive way to reflect a range of impaired renal function, from mild and transient to acute, severe
renal failure requiring dialysis. Unfortunately, in coding terms, “acute renal failure” equates to
“acute kidney injury,” although the terms are not synonymous for most physicians, Rothschild
says.

Show Physicians Their Own Documentation

AKI stages have been proposed to better represent different degrees of severity, but CMS
did not include the stages in the most recent update. “Stages I through III were proposed, but
were not implemented. They will likely try re-introducing some type of staging once we’ve
moved to ICD-10,” Rothschild says. Meanwhile, physicians and hospitals struggle with coding
and admission compliance for acute kidney injury, in part because of the lack of ICD-9 speci-
cicity of AKI severity (in contrast to chronic kidney disease, which has five stages), but also
because documentation often fails to sufficiently capture the condition, severity, and/or physi-
cian’s level of concern in a way that satisfies auditors, he says.

Hospitals start down the slippery slope to errors because the range of what constitutes an
injury is so great and documentation doesn’t always capture it.

“Any time AKI is present, logically there must have been an etiology — one or more insults
to the kidney, whether caused by something external, such as a car accident, or internal, such
as a kidney infection or irritation,” he explains. Regardless of the type of initial insult, what
matters is the degree of functional decline that ensues (i.e., the degree of acute renal injury,
possibly developing into chronic kidney disease). Elevated creatinine is the definitive clue.

It’s pretty common to see a mild increase in creatinine, and it can usually be treated with
hydration, commonly on an outpatient basis, Rothschild says. At the other extreme is acute
kidney injury that’s so severe it requires dialysis. Sometimes patients recover; other times they
progress to end-stage renal disease (ESRD). “It will be painfully obvious how sick they are in
these cases,” he says.

It’s the patients in the middle range of severity who are at risk of claims denials, Rothschild
says. They may need to be admitted, but RACs and other Medicare reviewers won’t be con-
vinced unless there is thorough documentation. It’s not always clear who should be admitted,
Rothschild notes.

Rothschild advises physicians to describe their concerns with phrases like “patient looks
concerning” or “not progressing as expected.” They should re-state labs in diagnostic terms
— “severe AKI, progressing” rather than vaguely noting “significant azotemia.” That’s what
auditors are looking for, he says. And document what is different. Instead of just saying the
patient’s creatinine is 0.5, note that there’s been a rapid rise in the creatinine and that the patient is mildly malnourished, has a history of XYZ and is in the ICU. “Paint a picture,” he says, “a specific, realistic picture — don’t make it modern art.”

When Rothschild works with hospitals on documentation improvement, he says he has found it useless to lecture physicians in the traditional way. Instead, he uses examples from their own charts. Otherwise, physicians may not believe they left out such critical diagnostic and treatment information. For example, the physician may have written, “the patient had no blood,” but he or she needs to write “anemia” so the coder can code it. Or the physician writes “CPR,” which explains that a life-saving technique was performed, but he or she never says the patient had a heart attack.

Ideally, Rothschild scans in the documentation from their charts because typing the information means he still has to overcome the skepticism of physicians who doubt they could have been so careless. “When you show them the chart, they say, ‘I see.’ If you don’t show them the chart, they say, ‘I don’t do that.’”

**CMS: MS-DRGs Shouldn’t Be Coded Until MD Documentation Is Done**

Hospitals invite Medicare claims denials when they assign MS-DRGs before physicians finish the medical records, according to June 22, 2011, guidance from CMS (MLN Matters SE 1121). Although recovery audit contractors (RACs) review the entire medical record during MS-DRG validations, CMS says, “hospitals may increase their chances of errors by choosing to code the case prior to receiving the complete medical record.”

For example, hospitals may be in a hurry to code cases and drop Medicare bills even though physicians haven’t finished their operative reports or discharge summaries. But this kind of key documentation can change the outcome of the case.

“The emergency room report, history and physical (H&P), and early progress notes may indicate the patient has one condition, but continuing workup and evaluation may determine something entirely different,” CMS says. “By having access to the complete medical record, more accurate codes can be assigned.”

RACs are finding that a substantial number of claims have the wrong principal diagnosis, CMS says. The principal diagnosis, which drives MS-DRG selection, is the condition determined after study to be mainly responsible for occasioning the patient’s admission to the hospital.

Mic Sager, compliance officer for Olympic Medical Center in Port Angeles, Wash., says the hospital doesn’t submit claims until it conducts a final review with all physician documentation. The chart is initially coded “but we wait for all physician documentation before the final coding of the chart,” he says. Obtaining that documentation can be an uphill battle because physicians are not always on top of it. Olympic implemented an initiative recently to ensure documentation is completed promptly. “We amended some of our contracts with certain physicians to include chart-completion standards,” Sager says. “And our chief medical officer dogged the physicians.” Olympic has more leverage in this area with its employed physicians.
In the *MLN Matters* article, CMS also says that hospital coders should query attending physicians when there’s “conflicting or contradictory information” about principal and/or secondary diagnoses. If the attending physician’s diagnosis doesn’t match the consulting specialist’s diagnosis and the coder doesn’t query, the hospital should code the attending physician’s diagnosis. But if the attending physician is silent on the subject, the coder can code the consultant’s diagnosis. None of this equates to an outright conflict between diagnoses (e.g., the attending physician says a patient has a sprained ankle and an orthopedist documents the same injury as a fracture). In those cases, “clinical evidence should be present in the medical record to support code assignment,” CMS says.

Although CMS says in the guidance that RACs consider all documentation, some hospital compliance officials say that isn’t the case. There have been complaints that documentation is not thoroughly reviewed and that RACs overlook evidence that supports a diagnosis, forcing hospitals to appeal overpayment determinations unnecessarily or forego reimbursement.

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**Hospitals Face Scrutiny in 16 Risk Areas in OIG’s Medicare Compliance Reviews**

As many as 16 risk areas are scrutinized during Medicare compliance reviews, the new breed of audits from the HHS Office of Inspector General.

Some of the potential errors, such as payments for hemophilia and post-acute care transfers, may come as a surprise to hospitals; others, such as septicemia, are long-time hot spots also targeted by recovery audit contractors (RACs) and the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Not all of the error types have been made public yet, but OIG has audited them during Medicare compliance reviews, says John Valenta, director of the health sciences practice at Deloitte in Orange County, Calif. So far, OIG targeted eight inpatient and outpatient risk areas during the two Medicare compliance reviews that were made public. That’s an extraordinary departure from the usual OIG audits, which tend to focus on one error type at hospitals and other providers and suppliers.

Medicare compliance reviews are also atypical because they delve into the back story of errors, with OIG identifying weaknesses in the hospitals’ internal controls and recommending improvements. For example, OIG questions hospitals on previous or current audits, whether internal or external (e.g., RACs), Valenta said in July 2011. “It seems like [OIG] is becoming more proactive — not just identifying errors on claims but trying to get to the root cause and what needs to be done to correct them,” he says.

Results of the first Medicare compliance review, which targeted South Shore Hospital in South Weymouth, Mass., were announced in March 2011. The second, announced in June 2011, focused on Fletcher Allen Health Care in Burlington, Vt.

Here are the 16 risk areas that OIG focuses on during OIG Medicare compliance reviews, although not necessarily all at once, according to Valenta:

- **Outpatient claims** billed during DRG payment window,
- **Inpatient manufacturer credits** for replacement of medical devices,
- **Outpatient manufacturer credits** for replacement of medical devices,
Post-acute transfers to SNF/HHA/another acute care/non-acute inpatient facility,
SNF/HHA consolidated billing — outpatient services,
Outpatient claims billed with modifier 59,
Inpatient claims paid greater than charges,
Outpatient claims paid greater than charges,
Inpatient payments greater than $150,000,
Outpatient payments greater than $25,000,
Payments for hemophilia services,
One-day stays at acute care,
Major complication/comorbidity and complication/comorbidity,
Payments for septicemia services,
Payments for inpatient same-day discharges and readmissions, and
Payments for outpatient surgeries billed with units greater than one.

The implementation of Medicare compliance reviews reflects advances in OIG’s data min-
ing. “The OIG is now taking advantage of some of the data mining and analysis it has been
conducting over many months, and it has come up with a list of areas it has found that contain
billing errors. Whether it’s valid remains to be seen,” says Valenta. While an analysis of vast
warehouses of Medicare claims data may point OIG in the right direction, the trail may prove
disprove actual errors once an audit is done. For example, OIG audited eight risk areas
during the first two Medicare compliance reviews. But the outcome was significantly different:
South Shore’s error rate was 64%, while Fletcher’s was 20%.

When hospitals become the lucky winners of the Medicare compliance review lotto, they
will receive an audit request. OIG requires hospitals to make copies of medical records that
support the claims that were selected for review, Valenta says. Two to four weeks later, audi-
tors appear at the hospital to conduct the audit onsite — although he says they may be amena-
able to an extension. “Any time the OIG knocks on your door it’s a little stressful and produces
anxiety,” he says. Notwithstanding the universal discomfort, “a lot can be said about how an
organization addresses an audit request. To the extent they are well-prepared and can present
documentation and do a review before OIG comes in so they can discuss potential problems
with the cases,” the experience will go more smoothly. “Hospitals that just make copies and
take the OIG criticism as it comes probably won’t impress OIG with their responsiveness,”
Valenta says.

Typically, OIG auditors stay from 4 to 12 weeks, depending on the number of cases they
review and how many issues arise during the audit, he says.

The focus on internal controls is a game changer. OIG doesn’t just determine whether the
end result — the Medicare claim — was correct. It wants to know what kind of reviews hos-
pitals perform to ensure the “ultimate submission of claims” is correct. “Inferring from what
I have seen, they want to make sure you don’t let information [get] slapped on a bill without
having the appropriate reviews in place” to verify, for example, patient demographic data and
the diagnostic and procedure codes that determine MS-DRG assignment. And OIG also ap-
ppears to check for ongoing auditing and monitoring when it conducts Medicare compliance
reviews.
Internal Controls Are Key

To promote best compliance practices, Valenta suggests that hospitals re-evaluate their internal controls, especially because they may face a Medicare compliance review. He says compliance officers should consider how their hospitals would describe:

1. **The roles and responsibilities** of departments/employees involved in claims billing and processing.

2. **Any contracts the hospital has** for processing payments and any billing related services provided by outside consultants.

3. **Any current or previous audits** performed by the hospital or outside agencies of the areas identified in the audit.

4. **The billing process**, internal controls and quality controls for inpatient claims.

5. **The billing process**, internal controls and quality controls for outpatient claims.

The 16 risk areas that are the focus of Medicare compliance reviews span the gamut. Some are long time compliance issues, such as one-day stays. Some are newer error types that are clearly a major concern to OIG because they alone have prompted audits. One example is manufacturer device credits for medical devices that are replaced when the warranty is still in effect, also known as explants; hospitals must pass these credits to Medicare.

Valenta says it’s a good idea to be prepared for Medicare compliance reviews. “Compliance officers should treat this as a serious government audit and establish a process for getting the records to the OIG for their review” and for handling additional inquiries, preferably in writing, he notes. “Establishing a timeline up front and being able to stick to it will help manage the OIG auditors while onsite.” ♦

Top 10 Upcoming Compliance Challenges: Putting Your Money Where Your Risks Are

Compliance is not for the faint of heart, with the deluge of program-integrity contractors, transformation of payment systems and crackdowns on nonprofits. It may feel less daunting if compliance officers prioritize their risk areas and take the long view when addressing them.

Boston attorney Larry Vernaglia in July 2011 described the top 10 compliance challenges that hospitals will tackle during the coming decade. “It sounds like a long time, but it’s not really in the life of a health care organization,” says Vernaglia, with Foley & Lardner LLP. “It may take 10 years to get value-based purchasing [institutionalized] or for accountable care organizations to be more than a pipe dream. And liability under the False Claims Act accrues over 10 years.”

Here are Vernaglia’s top 10 challenges for the next 10 years, which he says are interrelated:

1. **Quality-based payment liabilities:** The health reform law is helping speed “transformation” of a payment system that’s based on quality instead of volume through value-based purchasing, ACOs and Inpatient Quality Reporting, which are dependent on interoperable electronic health records, Vernaglia says. “There is a recipe for compliance disaster here. The rules are changing rapidly before regulators and providers know how to deal with them. They are building the car as they are driving it down the street,” he says. Despite the “massive financial
consequences, there’s little compliance apparatus and expertise.” For example, CMS bases payments partly on patient outcome and satisfaction measures. “If people make innocent mistakes or individuals figure out how to game the system before it’s implemented, that could have great impact,” Vernaglia notes. “No one will have safeguards and auditing protocols for a while.” Recommendation: When hospitals address quality-based payment initiatives, they should include compliance officers with care managers, clinicians and the others. “Get compliance people to think about how to test systems on the front end. There is a lag time between the creation of problems and the discovery of problems and you can shorten it,” Vernaglia says. Compliance officers can be the experts in testing for errors in the quality data that are used for Medicare payments, even if they’re not experts in generating the data.

(2) Individual liability: Enforcers are increasingly focused on people involved in alleged fraud, not just on the organizations. “The government sees it as an effective way to deter bad behavior,” Vernaglia says. If organizations pay millions in damages but violations persist, Medicare watchdogs assume excluding the puppet masters from Medicare or putting them in jail will get the message across, he says. So far, the focus has been on “the real bad guys”; the Department of Justice-HHS “HEAT” initiative has lead to prosecutions against dozens of alleged fraudsters. “But over the next 10 years, the feds will start excluding or putting away not-real-bad guys in greater numbers,” he says. Also expect to see executives and board members face the music under the “responsible corporate officer’s doctrine,” which holds that a director, officer, or employee can be held personally liable for a corporation’s civil liability under certain circumstances. Recommendation: When trouble is brewing, senior leaders may be inclined in this environment to look out for themselves at the expense of the organization, so the board may need independent counsel.

(3) Overpayments, the 60-day repayment mandate and the False Claims Act: The 60-day rule — which requires providers to return and explain Medicare and Medicaid overpayments within 60 days of identifying them — “is the most dramatic change in the enforcement regime in the past five years” and is already affecting compliance programs, Vernaglia says. Compliance departments are focused on this mandate almost to the exclusion of other responsibilities, such as training. “They are obsessed with refunding overpayments before they do the research,” he says. CMS could ease the burden in future regulations spelling out the 60-day rule, Vernaglia says. Recommendation: Beat this beast into submission. “The best organizations are squarely confronting this law now. They are having teams of folks actively thinking about how to interpret this law,” he says. For example, how can you turn on alarms so problems don’t sit too long? You want to set a process in motion when a problem is identified so it can be quantified, understood and explained — not shoved to the bottom of a pile on someone’s desk.

(4) Recovery audit contractors (RACs) and other contingency-fee auditors: If they recover enough money for CMS, then Medicare and Medicaid RACs will loom over the program-integrity landscape for the next decade. But it won’t be the same old, same old. More reviews may be performed remotely. “It’s Revenge of the Nerds,” Vernaglia says. “In the future, we will find a lot of [audits] won’t be based on medical records. There are plenty of databases that Medicare is pulling from and more information is generated electronically, so RACs sit at their desks and send overpayment determinations. It’s less labor intensive. If they want money, they will do it the easy way.” Imagine RACs using databases to identify certain errors, such as quality-reporting inaccuracies or improperly enrolled providers and the services they referred.
Meanwhile, RAC activity will spur more activity from Medicare administrative contractors (MACs). “MACs will get more aggressive because they don’t want to look bad when RACs find errors, especially when [MAC] contracts come up for renewal,” he says. Commercial payers have also adopted the contingency-fee model. “This is a dangerous and inherently error-prone business method, but it is here until legislators shut it down or providers deliver a few serious blows against the auditors in litigation,” he says. Recommendation: Beware MAC adjustments stemming from RAC overpayment identifications because you might get hit twice. Vernaglia says hospitals have voluntarily returned money pursuant to the 60-day rule, only to have the RAC ask for the money back for the same error. The hospitals have to prove they already made Medicare whole.

(5) Medicaid compliance: This area will pick up as state governments and the feds look for revenue and state and federal False Claims Act enforcement hits Medicaid. Not only are CMS’s Medicaid integrity contractors doing their thing (slowly), but Medicaid RACs will get to work in 2011. “As soon as you give bounty hunters incentives to find problems, they will

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<th>Overpayments and Underpayments Identified by RACs: New Data from CMS</th>
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<td>CMS has just posted these figures on the volume of overpayments and underpayments that have been identified, recovered and returned by its recovery audit contractors during the latest quarter of the national RAC program. The chart also states the top source of errors in each of the four RAC regions. Because provider appeals of overpayments take as long as a year, it’s possible the numbers will change if some overpayment determinations are reversed.</td>
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<tr>
<th>Medicare Fee for Service National Recovery Audit Program, 3rd Quarter, FY 2011</th>
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<tr>
<td><strong>Region A: DCS (Diversified Collection Services)</strong></td>
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<td>OVERPAYMENTS COLLECTED (3rd Qtr)</td>
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<td><strong>Region B: CGI (CGI Federal)</strong></td>
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<td><strong>Region C: Connolly, Inc.</strong></td>
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<tr>
<td><strong>Region D: HDI (HealthData Insights)</strong></td>
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<td>$112.2</td>
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<tr>
<td><strong>Nationwide Totals</strong></td>
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**TOP ISSUE PER REGION**

*Based on collected amounts through June 17, 2011

**Region A:** Renal and urinary tract disorders: (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with renal and urinary tract disorders needs to be complete and support all services provided.

**Region B:** Extensive operating room procedure unrelated to principal diagnosis: (DRG validation) Principal diagnosis & principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/ or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis–Related Group assignment.

**Region C:** Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided during an inpatient stay: (DMEPOS Automated Review) Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay.

**Region D:** Minor surgery and other treatment billed as inpatient: (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through June 30, 2011. Retrieved July 2, 2011.
find them,” he says. Recommendation: Shake things up to change the fact that “organizations with equal numbers of Medicare and Medicaid patients have vastly more information about Medicare compliance than Medicaid compliance.”

(6) Health information privacy and security: While the HIPAA rules are old news, leakage of sensitive information will get worse in the future as it’s shared across and outside health systems (e.g., among ACO players). Lewis Morris, chief counsel to HHS Inspector General Dan Levinson, emphasized this point during a July 12, 2011, hearing in the Senate, where he testified on harnessing technology to fight health waste and fraud. Although it’s an exciting frontier, he also cited the risks to electronic health and financial data. “CMS and state government data centers process hundreds of terabytes of data each month. To put this in perspective, a terabyte is equal to 220 million pages of text. This vast amount of data is transmitted with varying degrees of control and oversight. Trends show that health care data, including beneficiary and provider information, are stolen and sold by organized crime rings or individuals. Provider and/or beneficiary information is being compromised by social engineering schemes such as phishing emails. Data breaches of public and private entities have been occurring worldwide at an alarming rate. And the attacks are becoming increasingly sophisticated and stealthy,” Morris told a subcommittee of the Senate Committee on Homeland Security & Governmental Affairs. Recommendation: Compliance officers, who are well-versed in HIPAA, must think more broadly about the risks of EHRs and other HIT.

(7) Provider enrollment: There’s a disconnect between the government’s fixation on enrollment as a fraud prevention and enforcement tool and providers’ cavalier attitude about it. Vernaglia says the completion and updating of Medicare enrollment forms tends to be assigned to lower-level workers. “It does not have the attention of higher-level people,” he says. It should, he notes, because the stakes are high. CMS can yank Medicare provider numbers for failure to inform Medicare contractors of certain information, such as changes in board members or addresses. “This will be a source of risk in the future.” The health reform law empowered enforcers to use enrollment and payment suspension to protect Medicare and CMS regulations making the most of this. Recommendation: Develop new policies and procedures for enrollment form completion and oversight and implement protocols that enable your organization to identify errors on the front end, especially as health systems shape-shift, Vernaglia says.

(8) Conflict-of-interest law enforcement: “There will be continued interest in the overall notion of conflicts influencing referrals,” he says. Stark and kickback enforcement is one arena, and landmark cases are still pending against Tuomey Healthcare System in South Carolina and Bradford Regional Medical Center in Pennsylvania. Another intriguing area involves potential board member conflicts at nonprofit organizations. A dramatic case just unfolded in Massachusetts, where Attorney General Martha Coakley investigated nonprofit Blue Cross Blue Shield of Massachusetts after it gave the outgoing CEO $4.6 million in severance pay. “The investigation found that, under the terms of his contract, [CEO Cleve] Killingsworth was entitled to a significant payment upon his termination or non-renewal unless his removal was a result of intentional misconduct. Factors such as unsatisfactory performance and poor management or negligence still did not relieve BCBS of the legal obligation to make such a significant payment. The investigation found that contracts with similar provisions are held by the chief executive officers of other major health care organizations in Massachusetts,” according to the state AG’s office. After the investigation, Blue Cross Blue Shield board mem-
bers refunded the same amount to its ratepayers. Vernaglia says the suspicion is that board members aren’t fully independent when management makes decisions about their compensation. To address these problems, Coakley filed legislation to allow the AG’s office to prevent a charity from paying its board members “without justification,” according to a press release. Already, two health plans have voluntarily stopped compensating their board members. Recommendation: Nonprofits that pay their board members better think this through, Vernaglia says.

(9) **Board involvement in compliance:** “The government says boards need to be more on top of compliance failures. When they let management run amok, they are failing at their duties,” Vernaglia says. “This issue has been brewing for some time.” For example, OIG has made it clear that it will use its permissive exclusion authority to throw owners, officers and managing employees out of Medicare if their entity is excluded or convicted of certain offenses. Recommendation: Board training is essential. Compliance officers must teach board members what questions to ask about the compliance program and risk areas.

(10) **Nonprofit tax issues:** Tax exemptions for nonprofit hospitals face increasing scrutiny. As more hospitals (e.g., Detroit Medical Center) are bought by for-profit companies, questions are raised about whether there are meaningful differences between hospitals that pay taxes and hospitals that don’t. At the same time, nonprofits may jeopardize their exemptions when they turn to for-profits for joint ventures or to raise capital, he says. And the health reform law “has several provisions that turn up the heat on nonprofit hospitals,” Vernaglia says (see Sec. 9007(a), which affects Internal Revenue Code 501(r)). For example, starting in March 2012, tax-exempt hospitals must conduct a community health needs assessment at least every three years and set forth a financial assistance policy. Recommendation: “Nonprofit hospitals must distinguish themselves from for-profit hospitals,” he says. Provide additional services and “be really smart when doing it.” Also, keep an eye on the new health reform restrictions for non-profits.

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**RACs Audit Transfers to Post-Acute Care; Refunds to Hospitals May Be a Result**

Recovery audit contractors (RACs) are on the scent of errors stemming from the post-acute care transfer (PACT) rule. It’s designed to reduce reimbursement when acute-care stays are cut short, but RACs may find as many underpayments as overpayments, experts said in August 2011.

RACs are conducting automated reviews using the Medicare common working file, a giant database that holds the claims-processing history for all beneficiaries. The common working file is the key to validating claims for patients who were discharged to post-acute care. Hospitals, however, may not be taking advantage of it in their compliance monitoring.

“Incorrectly reporting the post-acute care discharge as ‘home’ is a compliance risk,” says Gloryanne Bryant, regional managing director of health information management for Kaiser Foundation Health Plan & Hospitals in Oakland, Calif. “However, compliance is not just overpayments but any payment that is paid incorrectly.”

The compliance risks of the PACT rule have grown with time as Congress has applied it to more MS-DRGs, Bryant says. The PACT rule dates back to the 1997 Balanced Budget
Amendment, which changed the way Medicare reimburses hospitals for certain patients discharged to post-acute care. The rule affects patients who are assigned to certain MS-DRGs if they are sent to post-acute care after staying fewer days than the national average for those DRGs, which is known as the geometric mean length of stay (GMLOS). These patients are reclassified as transfers, and hospitals receive per-diem payments for their care. Post-acute care is defined as home health services, skilled nursing care, and psychiatric and rehab facilities, and each is represented by a patient status code. In the beginning, Congress applied the PACT transfer policy to 10 DRGs, but it has been expanded to 273. Twenty-seven are considered “special-pay MS-DRGs” that qualify for a higher per-diem payment for the stay, she says.

“The PACT payment policy was based on the belief that it was inappropriate to pay the transferring hospital the full MS-DRG payment for less than the full course of treatment,” Bryant said at a webinar sponsored by RACMonitor.com.

CMS requires hospitals to use discharge disposition codes — also known as patient status codes — to indicate where patients go after leaving the hospital. Some of the most common codes are:

◆ 01: home
◆ 02: another acute-care hospital
◆ 03: skilled nursing facility (SNF)
◆ 06: home health agency services within three days of discharge
◆ 62: inpatient rehabilitation
◆ 63: long-term care hospital
◆ 65: psychiatric hospital

Under the PACT rule, Medicare pays hospitals twice the per-diem rate the first day of the hospital stay and the per-diem rate thereafter up to the full MS-DRG payment. There’s a boost for the 27 special-pay MS-DRGs because they are surgical. “There are huge upfront costs the first day the patient comes to surgery,” Bryant says. For day one, hospitals receive half the full MS-DRG payment plus the per-diem amount. On subsequent days, hospitals get half the per diem up to the full MS-DRG payment, she says.

### Patient Status/Discharge Disposition Code Tip Sheet

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>03</td>
<td>Transferred to a skilled nursing facility (SNF)</td>
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<tr>
<td>05</td>
<td>Discharged/transferred to designated cancer center or children’s hospital</td>
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<tr>
<td>06</td>
<td>Discharged/transferred to home under care of organized home health service organization (home health) within 3 days of discharge</td>
</tr>
<tr>
<td>62</td>
<td>Discharged/transferred to inpatient rehabilitation facility, including rehabilitation distinct part/unit of a hospital</td>
</tr>
<tr>
<td>63</td>
<td>Discharged/transferred to a long term care hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged/transferred to a psychiatric hospital or psychiatric distinct part/unit of a hospital</td>
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When the facility transfers/discharges a patient to any of the above dispositions by assigning the patient status code 03, 05, 06, 62, 63 or 65 and the length of stay is less than the GMLOS: The hospital/facility receives twice the per diem rate for the first day of the stay and the per diem rate for each remaining day up to the full MS-DRG payment. Certain MS-DRGs are designated as part of the special payment MS-DRG (expanded transfer DRG) and the length of stay is less than the GMLOS: The facility receives 50% of the full MS-DRG payment plus the per diem rate for the first day of the stay and 50% of the per diem rate for each remaining day up to the full MS-DRG payment.

SOURCE: Gloryanne Bryant, Regional Managing Director HIM, Kaiser Foundation Health Plan Inc. & Hospitals.
Home Health Plans May Change

Medicare calculates per diems by dividing the MS-DRG payment by the GMLOS for that MS-DRG. For example, payment for nutritional and miscellaneous metabolic disorders (MS-DRG 641) is $4,149.60 (assuming a hospital base rate of $6,000). The GMLOS is 2.9 days, so the per diem is $2,841.78 for the first day and $1,420.89 for the second day. If the patient’s hospital stay is within a day of the GMLOS, the per-diem payment more or less equals the MS-DRG payment.

The PACT rule is a longtime risk area because of the potential for overpayments, but now RACs have gotten in on the act. There is a lot of room for error, particularly with home health care and skilled nursing.

If patients are discharged from the hospital and the physician orders home health within three days, the PACT rule applies, and the hospital will be paid per diems (if the length of stay is less than the GMLOS). But sometimes things don’t go according to plan. Sometimes families decide to take care of their loved one after discharge. If that proves too overwhelming, the family calls the physician directly and asks for the home health order after the fact, Bryant says. The last thing on everyone’s mind is to notify the hospital that plans have changed; why would they? Meanwhile, the hospital has submitted a claim with a discharge disposition code of 01 and collected full MS-DRG reimbursement, which is a risk.

It’s easy enough for RACs to identify this overpayment. As soon as relevant claims are processed, the information is in the common working file. The RAC identifies patients who received home health services within three days of discharge from the hospital, and if the hospital was paid the full MS-DRG rate instead of a per diem, there has been an overpayment, Bryant says. It’s frustrating for hospitals because there’s no way they could have known that home health plans changed “without having exceptional communication lines internally and externally,” she says.

For example, a 70-year-old female is admitted to the hospital for cardiac valve surgery. Her children vow to take care of her, so she is discharged home. Medicare pays the hospital $26,880 (assuming a hospital base rate of $6,000) for MS-DRG 221 (cardiac valve surgery without complications or comorbidities) with a GMLOS of 4.48 days. But the kids can’t cope with their mother’s needs and ask the physician to order home health care. When the RAC looks in the common working file and sees that the hospital was paid the full freight for this patient despite the transfer to home health care, it recoups the difference between the MS-DRG payment and the per diems for the two days she is in acute care. The per diem is $4,700, except for the first day, when it’s $18,140 because surgical DRGs are paid at the special PACT rate.

Another compliance risk arises at nursing homes, says David Jupp, CEO of MCare Solutions in Houston. Patients may be discharged to custodial care in a nursing home, which doesn’t trigger the PACT policy. But on arrival, the nursing home may determine that the patient requires skilled nursing, which means per diems for the hospital, Jupp says. “The nursing home doesn’t call the hospital to say, ‘this patient needs skilled care,’ but they submit the claim for skilled care,” he says. “There’s a compliance risk if you use 04 [i.e., custodial care] and the patient ends up in skilled care because you may have been overpaid.”

His solution: Hospitals usually use a couple of nursing homes/SNFs and should capitalize on their desire to please referral sources. “Have SNF admitting nurses come to the hospital and look at the medical records and decide whether the patient will probably need skilled
care,” Jupp says. “Then discharge planning people will put a note in the chart saying, ‘the patient will receive skilled care versus custodial’ so coders will have a better idea what will happen as opposed to a note from a physician saying, ‘transfer to skilled care.’”

Notwithstanding the overpayment fears, Jupp says underpayments are more likely with the PACT rule. Though hospitals consistently make discharge disposition coding errors — usually because they are not informed of changes in a patient’s post-acute care status — their Medicare administrative contractors figure it out and adjust the payment. The RAC has seized on this area only because of concerns raised by the HHS Office of Inspector General, Jupp says.

Underpayments are another story, says Jupp, who has worked with 200 hospitals on PACT issues. Patients get referred for home health or skilled nursing and don’t qualify, but the hospital never finds out, so it bills the patient as a transfer. In fact, his research shows that 1.2% of all discharges have a discharge disposition coding error, evenly split between SNF and home health. All the home health errors resulted in underpayments, Jupp says.

Life with RACs can get weird. One hospital received a $3,000 refund stemming from a RAC audit. The RAC insisted that the hospital was owed the money because a patient did not receive home health care after discharge from the hospital, even though the hospital billed the patient as a transfer with an 06 discharge disposition code. The hospital informed the RAC that it was not entitled to the refund because the patient did receive home health care — and the hospital had medical records to prove it. But the RAC refused to process a refund of the refund because there were no home health claims for that patient in the common working file. The hospital is still struggling with a solution, as it is certain the money belongs to Medicare, but the RAC insists it doesn’t.

Validating discharge disposition codes to improve PACT transfer policy compliance is not really that complicated, Bryant says, but it is time-consuming. The best bet is to use the common working file in your validation processes. It maintains all beneficiary claims data since 1989. “RACs are using the common working file to validate discharge disposition codes, and this is being done through automated reviews,” she says. The common working file shows patient movement among different levels of care. “This is a link for RACs into improper payment specific to discharge patient status codes.”

Medicare condition codes — which are required for discharges to home health care and SNFs — also play a role in PACT compliance, Bryant says. Hospitals are required to put condition code 42 on the UB billing form when home health or SNF services are not related to the inpatient hospital admission, she says. Hospitals must use condition code 43 when home health or SNF services are related to the inpatient admission (based on diagnosis codes) but don’t start within the three-day window after discharge. For example, if a patient’s hip fracture is related to his/her admission, but home health care doesn’t begin until four days after discharge, the hospital must report condition code 43 to ensure full MS-DRG payment, Bryant says. “It’s a little caveat people often don’t know about or gets missed in claims processing.”
Health System Reaches Settlement After Assigning the Wrong DRGs

Septicemia and respiratory failure — two longtime risk areas — are at the heart of a false claims lawsuit with a Louisville, Ky.-based health system and a facility it manages.

Baptist Healthcare System will pay almost $5.8 million to settle claims that its hospitals submitted claims with incorrect DRGs, and Hardin Memorial Hospital (which Baptist manages) will pay $3.1 million, according to the U.S. Attorney’s Office for the Western District of Kentucky.

The allegedly incorrect claims involved DRGs 79 (respiratory infection and inflammation age greater than 17 with complications and/or comorbidities), 87 (pulmonary edema and respiratory failure) and 416 (septicemia in individuals older than 17). The conduct occurred between Jan. 1, 2001, and Dec. 31, 2006, the feds said in summer 2011.

All three DRGs are considered high-risk areas and are targets of recovery audit contractors (RACs) and CMS’s Program to Evaluate Payment Patterns Electronic Report (PEPPER). In 2007, CMS split DRG 416 into three MS-DRGs (870, 871 and 872), which now appear on RAC audit lists. RACs have also said they would go back and validate DRG 416. Respiratory failure has been error prone because of miscoding or sequencing issues involving pneumonia and chronic obstructive pulmonary disease.

The feds say the erroneous use of the DRGs by the six hospitals “resulted in higher reimbursement rates than warranted by the actual condition of patients treated at the hospitals.” The U.S. attorney says the legal claims are based on payment by mistake and unjust enrichment. A spokesperson for the U.S. attorney’s office says a Medicare program safeguard contractor referred the case to them. He says the settlement took so long because the issues were complex and involved tens of thousands of documents, plus medical and coding reviews for the six facilities, on top of “lengthy settlement discussions” by the parties.

The health system does not admit liability.

“The hospital system and the U.S. Department of Justice (representing Medicare) have been in discussions involving billing for three medical conditions over a six-year period (2001-2006),” Don Riggs, vice president of compliance for Baptist Healthcare System, says in a statement. “Billing for certain medical claims was the sole issue, and whether the coding reflected the severity of each case. Billing codes are complex, and different codes can be selected for each diagnosis, in addition to designating the different level of severity or complications.”

“Both Baptist and the Department of Justice had independent third-party reviews performed on the disputed claims, each reaching different conclusions. After lengthy negotiations, we agreed to disagree, and Baptist decided it was best to settle,” Riggs adds.

A spokesperson for the health system would not say what corrective actions Baptist has taken to ensure that the errors do not happen again. ☣
Some Compliance Programs May Fail to Reduce the Risks Of False Claims

Hospitals put themselves in the line of false-claims fire when they don’t act on information that could identify billing errors or update their compliance programs in response to new enforcement activities, a federal prosecutor says.

“I often hear compliance officers talk in the following language as it relates to right versus wrong: Conduct is characterized as either intentional fraud or inadvertent overbilling, as if there is nothing in between. But there is a range of conduct between inadvertent good-faith mistakes and criminal wrongdoing — and that is the False Claims Act,” says Assistant U.S. Attorney Robert Trusiak, head of the national kyphoplasty admission-necessity enforcement initiative. “Unless they recognize there is a breadth of misconduct between them, compliance programs are not doing what they should be doing, which is in part mitigating their liability under the False Claims Act,” he told AIS in September 2011.

This mutually exclusive thinking is riskier in the new enforcement environment that includes the 2009 Fraud Enforcement and Recovery Act, which makes it a violation of the False Claims Act to knowingly retain Medicare overpayments; the health reform law requiring the return of Medicare and Medicaid overpayments within 60 days of identifying them; and the rise in Medicare and Medicaid reviewers, such as recovery audit contractors (RACs) and zone program integrity contractors (ZPICs).

The Department of Justice has its eye on billing errors identified by program-integrity contractors. When auditors identify billing errors, they go back only so far in the hospital’s billing history. RACs, for example, have a CMS-mandated three-year “look-back” period. But investigators may follow the trail of bread crumbs further back in time, says Trusiak, who is chief of the affirmative civil enforcement unit in the U.S. Attorney’s Office for the Western District of New York. “An argument can be made that the hospital avoided repayment” because it did not audit a billing error identified by a RAC or ZPIC for times that predated the audit, he says. It’s not a tough case for the Department of Justice to make, he says: “You had to repay this money so you knew there were incorrect claims submissions, but didn’t undertake the pedestrian step of getting back to the billing misconduct and addressing it. The compliance program that doesn’t grasp the realities of the multitude of RAC and ZPIC audits is leaving that hospital exposed to False Claims Act liability,” he says.

Given developments like the new law and its interface with the audits, compliance programs should be “regularly and critically analyzed to assure [their] continued reliability in the same way we check our smoke detector batteries every fall when we turn back our clocks,” Trusiak says.

Hospitals Are Obligated to Interpret Outliers

The standard of proof for an FCA case is reckless disregard or deliberate ignorance, which fall along the continuum between innocent errors and criminal behavior. For example, if hospitals receive information that their billing is way out of line, the government expects them to act on it. The Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) are free quarterly reports generated by CMS that compare hospital billing in the state, Medicare administrative contractor (MAC) jurisdiction and country in certain risk areas. When hospitals
are outliers in a risk area, they are expected to audit medical records and find out if there’s a compliance problem or a reasonable explanation.

“To the extent the hospital is always on the high end of the PEPPER report, does that mean there is False Claims Act liability? Of course not,” Trusiak says. “But a hospital needs to police the PEPPER reports” and has an obligation to assess, analyze and explain billing outliers.

“Compliance programs have to do more than say ‘we won’t take kickbacks or employ excluded people,’” Trusiak says.

Compliance officers often think it’s the Department of Justice that judges hospital conduct in a bilateral way — fraud versus errors, says Washington, D.C., attorney Heidi Sorensen, with Foley & Lardner LLP. While compliance officers generally understand the gray area in between and are well-versed in the concepts of reckless disregard and deliberate ignorance, they worry that the government doesn’t appreciate Medicare’s complexity and applies the False Claims Act where it doesn’t belong, she says.

“One thing that concerns the provider community is the difficulty in impressing on folks who haven’t worked in the industry that it’s not always as black and white as some DOJ attorneys might perceive it to be. It’s a reflection of the background of folks who come from different perspectives,” says Sorensen, former chief of the HHS Office of Inspector General’s administrative and civil recoveries branch. Since counsel for providers and government attorneys don’t tend to walk a mile in each other’s shoes, however, they may continue to “disagree factually,” she says.

**Four Angles for Updating Compliance Programs**

Trusiak encourages compliance officers to use their compliance programs as a shield against the False Claims Act. That means keeping compliance programs “dynamic,” he says, and critically assessing them to:

1. **Keep up with current enforcement efforts.** Compliance programs shouldn’t focus only on early targets, such as DRG window unbundling and Physicians at Teaching Hospitals. “Any compliance program seeking to avoid false claims liability better audit areas of current liability. So if DOJ is addressing site of service, you better audit site of service,” Trusiak says. In addition to site of service (i.e., medical necessity of admissions versus observation), hospitals may want to be aware of the liability risks stemming from nonemployed physicians.

2. **Account for statutory changes.** For example, “FERA was very powerful” because of its “expansion of reverse false claims,” he says. “This change ensures if a facility is aware of an overpayment and conceals it and knowingly and improperly avoids it, then it may be liable under the False Claims Act.”

3. **Insert compliance into some decisions about new service lines.** “The decision whether to permit physicians to employ new procedures is a multi-faceted process, including clinical and financial considerations. The inclusion of the compliance officer will help ensure the institutional provider credits the clinical considerations in addition to the legitimate cost and reimbursement considerations,” Trusiak says.

4. **Make sure the compliance program accurately defines** the conduct it seeks to guard against, including the False Claims Act.
Some compliance officers continue to overlook the potential for false claims cases because their hospital didn’t set out to commit fraud, Trusiak says. “Many people misapprehend the type of conduct that can be problematic for their facility — good-faith mistakes versus fraud — but if it’s reckless or deliberately ignorant it can implicate the False Claims Act,” he asserts. He cites the example of a hospital he investigated for emergency department upcoding. For three years in a row, the hospital coded at the highest level for all ED visits that culminated in admissions. Then the coding went back to normal — a bell curve — for a year before spiking again. It turned out the highest-level codes were the work of one coder who had the weird idea that ED patients should be coded at the highest-level evaluation and management service if they were later admitted as inpatients. The reason ED coding was normal for a year was the coder had a baby and went on maternity leave. Although the coder made an innocent mistake — she implemented a coding “rule” she learned, and misinterpreted, at a conference — the hospital neglected to identify the problem and fix it. “If you recklessly assign codes contrary to CPT rules, that may imply recklessness,” Trusiak says. “The compliance plan needs to address that.” The hospital wound up settling a false claims case with the U.S. attorney’s office.

Sorensen doubts there is a wealth of false-claims fodder in RAC, ZPIC and other Medicare and Medicaid reviews. There’s often a reason why hospitals don’t audit all historical claims that potentially have the same billing errors. The RAC audit may have identified non-compliance with a new coding rule that took effect, for example, in 2008. Consequently, there wouldn’t be any reason to look back further than 2008. Plus the reopening period for Medicare, absent fraud, is four years, and the False Claims Act statute of limitations is six years. “There isn’t always going to be False Claims Act liability,” she says. Sometimes, though, the hospital identifies a long-term problem when it conducts a root-cause analysis to get to the heart of a problem identified by a Medicare or Medicaid auditor, she notes. In that case, the provider is going to want to audit a longer time period than the RAC or ZPIC initially identified.

**Medicare Auditors Target Place-of-Service Codes; Provider-Based Status Is at Risk**

Medicare auditors are bearing down on place-of-service errors at the same time that hospitals are spotting POS problems on their own. Mistakes in this area could cause overpayments and jeopardize the status of provider-based entities.

Using the wrong place-of-service code triggers overpayments because Medicare Part B pays more for certain physician services when they are provided at offices or freestanding clinics rather than at hospital departments, including provider-based entities. The reason: professional fees include overhead when services are provided at practices and freestanding clinics. But Medicare Part B reduces professional fees when physicians treat patients in outpatient departments, because hospitals foot the bill for overhead and recover the money through APC payments for facility fees.

Payment accuracy hinges on physicians informing Medicare where they provided the services, which is where POS reporting comes in. Three codes take center stage:

- **POS code 11 (offices),**
- **POS code 21 (hospital inpatient departments), and**
◆ **POS code 22 (hospital outpatient departments, such as provider-based entities).**

Apparently, however, compliance in this area has fallen short of CMS expectations. The HHS Office of Inspector General 2012 Work Plan targets incorrect reporting of the place of service — also known as site of service or facility vs. non-facility reimbursement — and a recent Medicare update on recovery audit contractor (RAC) findings cites them as a big source of overpayments.

Hospitals may endanger their provider-based status through place-of-service errors. “One of the conditions of provider-based status is that physicians use the correct place of service on their claims,” said Washington, D.C., attorney Andy Ruskin, with Morgan Lewis & Bockius, in December 2011. “It’s not just the claim that’s in jeopardy.”

Hospitals should keep their eyes open for POS errors. The overpayment liability alone can be painful, and compliance experts say they routinely run across problems in this area.

One hospital just realized it submitted 8,000 claims to Medicare with the wrong place-of-service code during a two-month period, says its compliance officer, who wishes to remain anonymous. The claims had POS code 11, which is used when services are provided at a physician office. But the services were actually provided at the hospital’s provider-based clinics, and therefore should be billed with POS code 22.

The hospital’s problem was identified Nov. 23, 2011, by a biller who was working on a claims denial. She realized the POS code was wrong and immediately told her manager. “The manager called me right away,” the compliance officer says. “From the time the billing clerk found the error to the time I knew about it was two hours.” The hospital immediately suspended all claims from the provider-based clinics and drafted a letter to its Medicare administrative contractor disclosing the error.

**A Software Update Caused the Problem**

The origin of the problem was a software update. The hospital vendor fixed a glitch in the professional billing system involving bilateral modifiers to CPT codes. Unfortunately, the vendor sabotaged POS codes. POS 22 morphed into POS 11, and the vendor hard-wired it into the system so every service performed at the provider-based clinics would be billed as if it were provided at a private practice or freestanding clinic. The net effect: the hospital was overpaid for all physician services at its provider-based clinics.

A day after discovering the problem, the hospital implemented a workaround and then corrected the software, allowing it to resume claims submissions with the correct POS code. But now the hospital turns to the unpleasant task of manually reprocessing the erroneous 8,000 claims. It would be easier to just repay the overpayment, but the compliance officer doubts the MAC will go for that. Reprocessing is probably necessary to fix beneficiary copayments and secondary insurance also inflated by the POS error. “Medicare wants the common working file to be accurate and to [restore] the integrity of the data,” the compliance officer says. Otherwise, it looks like the 8,000 claims were submitted for people treated at freestanding clinics when they were actually treated at provider-based entities.

The experience underscores the importance of monitoring and not just auditing. “We would have caught this long before if we had appropriate monitoring in place,” the compliance officer says. Even just screening five claims a week would have offered some comfort that claims
were submitted correctly because the hospital bills on behalf of all employed and contractor physicians at its provider-based clinics. The other option is a contract management system, which detects payments that don’t square with the level of service, place-of-service code, etc. But they’re pricey, the compliance officer says, and probably out of reach for smaller and/or cash-strapped hospitals.

Improving compliance with place-of-service codes is harder for hospitals that don’t employ physicians at provider-based entities, notes Cheryl Storey, a health care partner in the accounting firm Moss Adams LLP. “Hospitals don’t have any control when physicians do their own billing,” she notes. She recommends that their contracts with the hospital require them to use POS code 22 in specified departments, but it’s difficult to enforce.

The stakes are high for hospitals because incorrect POS codes put a provider-based designation at risk, Ruskin says. According to CMS’s provider-based regulations (42 C.F.R. § 413.65), “physician services furnished in hospital outpatient departments or hospital-based entities… must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined.” Therefore, if a hospital’s physicians are noncompliant in this regard, it’s possible that all of the clinic’s claims have been overpaid, and not just the ones where the physicians used the wrong site of service, Ruskin says. This would hold true even if the physicians are not hospital employees and merely have medical-staff privileges that allow them to work at the clinic.

**Three Tips Offered for Physician Compliance**

Ruskin offered these three tips to prod physicians into compliance:

1. **Require physicians to sign certifications** that they understand the billing rules and will include the correct site of service;

2. **Post signs that remind physicians and patients** they are walking into provider-based space and furnishing, or receiving, provider-based services; and

3. **Check in with physicians** on place-of-service coding (e.g., email reminders).

Nothing about this will be easy. “Hospitals are relying on physicians who have nothing to gain by doing it correctly,” Ruskin says. But a hospital’s good faith will go a long way with CMS auditors who may be tempted to yank provider-based status over POS errors, he says. That would be bad for hospitals, which collect more reimbursement for services at provider-based entities versus their freestanding clinics.

Another angle to POS compliance is misuse of POS 11 when physicians should have reported POS 21 (hospital inpatient setting). This issue is emphasized in CMS’s recent Medicare quarterly provider compliance newsletter. The edition is exclusively devoted to RAC findings, and first up on the list is POS errors generally, which it calls “site-of-service differentials,” though CMS is preoccupied with the inpatient switch.

Generally, CMS says the worst offenders are:

- **CPT code 99291**: Critical care first hour;
- **CPT 85097**: Bone marrow interpretation;
- **CPT 96118**: Neuropsychological testing; and
- **CPT 90801**: Psychiatric diagnostic interview examination.
But only two examples are given, and both involve physicians reporting services provided in their practices or freestanding clinics when they were actually performed on hospital inpatients.

Inpatient-related POS errors may reflect the confusion among physicians about what services are included in the professional versus technical fees, says Peggi-Ann Amstutz, a senior manager in the health care group at Moss Adams. “We see a lot of interpretation errors and incorrect application of that concept,” she notes. Physicians are providing services in a facility but they represent the professional part of the claim, and at some point they figure they will just let the hospital billing system figure it out for them. That’s an invitation for billing errors unless there are edits to catch it, but physicians take the attitude that they “didn’t go to school to be a coder.” So what starts out as a simple concept — was the service provided in your practice or the hospital? — becomes muddled, Amstutz notes.

“I think there’s a disconnect with education and understanding of POS. It’s not well-understood in the physician practice world,” Amstutz says. Hospitals can improve compliance by upping education in this area for physicians and billers who enter data in the system. “They won’t even ask the question because they don’t know what they don’t know,” she says.

MS-DRGs Targeted in RAC Prepayment Demo Raise Red Flags Despite the Delay

Although CMS has postponed its RAC prepayment review demonstration, the MS-DRGs that face scrutiny are potential risk areas for all hospitals. They include syncope, which is a top cause of medically unnecessary admissions, and gastrointestinal bleeding, a RAC postpayment audit target.

At the same time, the delay in the RAC demonstration, announced Dec. 29, 2011, probably hasn’t dampened CMS’s enthusiasm for prepayment reviews, because they prevent overpayments instead of defaulting to after-the-fact recovery.

“Prepayment review is a way to fix the error rate,” George Mills, director of the CMS Provider Compliance Group, told AIS in January 2012. Medicare administrative contractors (MACs) are doing MS-DRG prepayment reviews around the country, he says, as well as prepayment reviews of other claim types based on findings from the Comprehensive Error Rate Testing (CERT) contractor. “We are focusing on where we can get the biggest bang for our buck.”

Mills emphasizes, however, that hospitals won’t be double-whammied — subject to a prepayment review and a postpayment review on the same claim. RACs and MACs are required to develop joint operating agreements, which include procedures “to ensure that a RAC and a MAC are not looking at the same provider at the same time for the same issue,” he explains.

Whether there’s prepayment or postpayment review by RACs and MACs, the process for defensible claims is the same, says Ralph Wuebker, M.D., vice president of the audit, compliance and education physician team at Executive Health Resources in Newtown Square, Pa.

It’s a triad: physician documentation of the patient’s condition and its implications; first-level screening by case managers for admission necessity; and second-level physician review. “If you have all the pieces in place, that will be the core of your defense, whether they review prepayment or three years down the line,” Wuebker says.
When it resumes, the RAC prepayment demonstration will focus on both coding and admission necessity for eight MS-DRGs, for starters. Even if the demo gets shelved, these MS-DRGs are risk areas:

- **Syncope and collapse** (MS-DRG 312),
- **Transient ischemia** (MS-DRG 069),
- **Gastrointestinal hemorrhage with complications and comorbidities** (MS-DRG 378),
- **Gastrointestinal hemorrhage** with major CC (MS-DRG 377),
- **Gastrointestinal hemorrhage** without CC/MCC (MS-DRG 379),
- **Diabetes with MCC** (MS-DRG 637),
- **Diabetes with CC** (MS-DRG 638),
- **Diabetes without CC/MCC** (MS-DRG 639).

Mills says it’s unclear why syncope is a big problem. “However, based on national CERT data, there is a consistent trend that beneficiaries are admitted when their medical condition warrants observation when Medicare receives a short stay claim for syncope,” he notes.

**Documentation of Etiology Is Key**

Physician documentation is the heart of compliance for all these MS-DRGs. “Physicians tend to focus on a symptom-based diagnosis instead of what is really going on with the patient,” he says. With syncope, physicians may document the patient was weak and dizzy and needed IV fluids. But “what differentiates [inpatient and outpatient care] and keeps physicians out of trouble” is explaining the cause of the syncope for that patient. Is there a neurological or cardiac etiology, meaning the patient is at risk of stroke or heart attack? Or is inner ear infection the culprit? “Getting physicians to say ‘here are my suspicions, here is what I am concerned about’ is very significant,” Wuebker says. They don’t have to be right in the end; they just have to write, from the beginning, what symptoms may mean.

When it comes to documentation, the diabetes and gastrointestinal MS-DRGs in particular are tricky.

To support admissions for GI bleeds, physicians should bridge the gap between the patient’s symptoms and the need for acute care (or observation placement), Wuebker says. GI bleeding could be chronic, caused by a hemorrhoid or ulcer, or acute; “there’s a big difference if someone is living with a GI bleed from diverticulosis and losing a unit of blood every day and is lightheaded and dehydrated,” he says. It’s essential for physicians to document the pertinent clinical findings when they decided to admit the patient, and say “here is what is running through my thought process,” he says. Was the hemoglobin lower than a previous reading ordered at the doctor’s office? Is the heart rate higher?

When physicians don’t connect the dots, he will call them and say, “are you thinking colon cancer with this patient?” It requires teasing out their thoughts in a conversation that lasts two to four minutes. Auditors generally don’t do this, Wuebker says. “They usually focus on physician notes and typically don’t look at supporting information — nurses’ notes, lab reports — so if all the physician has written is a symptom and treatment plan,” auditors have no clear picture of what drove the physician to be concerned about the patient to the point of ordering admission.
Physicians have to tell the story, but that doesn’t mean they have to write a novel. A one-page history and physical in the progress notes could suffice as long as physicians include three to five sentences on their impressions and medical decision making. “That is very solid from a defense perspective and you will be more successful overall in the appeal process,” he says. But often that doesn’t happen.

For example, when patients are admitted through the emergency room with chest pain, often physicians will write “chest pain, EKGs, troponins, oxygen, stress test in the morning.” Little is mentioned about the physician’s worries, which are a big trigger for an admission. Is the chest pain probably from nachos and beer and the physician is being extra cautious? If so, auditors will expect that patient to be placed in observation. If the physician documents that he fears a heart attack, that’s a different story.

**CMS Must See Diabetes Warning Signs**

Diabetes as a site-of-service compliance risk came as a surprise because it’s not a classic compliance issue. The CMS Program for Evaluating Payment Patterns Electronic Report (PEPPER) doesn’t include diabetes, although at least one RAC is auditing inpatient medical necessity for diabetes on a postpayment basis. Obviously, though, CMS has data indicating there are admission troubles in this area given its selection for the prepayment demo.

Diabetes is like chest pain — whether an admission is medically necessary depends on multiple factors and it’s not always clear when the patient is out of danger and ready to be sent home. Clinical markers, such as blood-glucose levels, may not tell the whole story, Wuebker says. Insulin-dependent diabetics whose blood-glucose levels are off the charts could develop DKA and land in the ICU, something that’s also happening more with noninsulin-dependent diabetics. If the clinical markers are normal in 24 hours, they may be sent home, which shows “you can’t rely on length of stay” to determine medical necessity, Wuebker says.

Other relevant factors include the patient’s age, the type of diabetes (insulin or non-insulin dependent) and comorbidities (e.g., lung or heart disease). “If it’s not treated properly, you get brain swelling and can die,” he says. “Just because the patient goes home in 24 hours doesn’t mean the patient is low risk.”

CMS’s embrace of prepayment reviews reflects its desire to determine if a claim is appropriate before paying rather than chasing the money after Medicare has paid the bill. It’s the kind of strategy used by the commercial insurance industry, which screens procedures and admissions before or as they occur, targeting high-dollar and/or borderline cases, he says. Prepayment reviews won’t accomplish quite the same thing because they still take place weeks or months after patients have left the hospital. But they cut the lag time of postpayment reviews.

Targets of MAC prepayment reviews are announced on each MAC’s website and hospitals should look there for a heads-up, Mills says. “We hope by catching [errors] upfront, it serves as an educational tool,” he notes. ✤
Medical Necessity and Coding Challenges Make Wound Care a Ripe Audit Target

Turning over the rocks in wound care centers may expose billing, coding and documentation problems, and help hospitals tackle more systemic deficiencies. Medicare administrative contractors (MACs) are already tightening the medical-necessity screws, and wound care may be a big target when recovery audit contractors (RACs) expand their scrutiny of medical necessity from the inpatient to the outpatient side.

“Hospitals have a lot of clean-up to do in the outpatient world and they have to do it now before RACs get too deep into it,” says Toni Turner, executive director of InRich Advisors in Houston.

Wound care centers are very complex partly because they don’t have a special designation. They are not recognized as a specialty service by Medicare and don’t have a revenue code. Wound care is not one of the 24 American Board of Medical Specialties, and wound-care patients run the gamut in terms of conditions and comorbidities. In their own little bubbles, wound-care centers are physician-directed clinics billed under the hospital outpatient prospective payment system, Turner said in early 2012. And challenges crop up all the time, such as new CPT codes for skin grafts that took effect Jan. 1, 2012.

Meanwhile, a number of hospitals reportedly are under investigation for their use of hyperbaric oxygen therapy, a hospital-based treatment for wounds and other conditions. They face scrutiny for billing, medical necessity and physician supervision.

Even if hospitals aren’t facing an enforcement action, they may experience MAC or RAC reviews. “Some coders are not familiar enough with the clinical setting to see what they are billing for, and national clinical guidelines are limited and not well known to many of the clinicians, so they are not documenting key components of care that contractors and payers want to paint medical necessity,” Turner says. “Auditors shouldn’t have to come educate.”

Some of the pressure on wound care comes from MACs, which want proof that wound care is medically necessary. As wound-care technology evolves, local coverage decisions have become “deeper and more detailed,” Turner says. “Many dressings and products are living things — they are not just covering up wounds — and there are big dollars for some of these things and potential for abuse. It raises the compliance standards.”

For example, National Government Services’ local coverage decision for skin substitutes — “Biologic Products for Wound Treatment and Surgical Interventions” (L26003) — is 15 pages long, plus there are separate “articles” for each product in this category (e.g., Apligraf). The Apligraf article sets forth coding, utilization, modifiers, place of service and documentation requirements for Medicare payments. NGS’s LCD for hyperbaric oxygen therapy is 26 pages long.

But clinicians may not always rise to the documentation challenge, Turner says. “Medical necessity is an incredibly big issue with these patients,” she says. The problem is connecting the dots between diagnosis and medical necessity. “A lot of clinicians and coders don’t really understand the difference between documenting indications and documenting medical necessity in wound centers.” Indications are the diagnoses that pass medical-necessity muster on the front end, while medical-necessity documentation provides evidence that services are used correctly and patients are improving, she says. “There’s a difference between indication
of need and medical necessity, and making a diagnosis is easier than painting a picture of why patients need the next treatment or modality. Medical necessity is spread throughout a patient’s chart. What do the labs look like? How has the patient responded to care previously? Auditors are not just looking at one encounter or one procedure note. They are looking for a story,” Turner says. Wound care services, such as hyperbaric oxygen therapy and skin substitutes, are expensive and repeated, and auditors may deny claims if they aren’t achieving the desired outcome.

**EHRs Provide New Challenges**

There are also documentation challenges with electronic health records (EHRs). While automated tools are necessary to capture the detail required by LCDs, Turner says, hospitals need to understand what features are important to make data input meaningful. “Clinicians may have a false sense of security that they are being compliant with documentation [standards] because of EHRs,” she says. They are putting a lot of data into the fields, but if the software does not have the payers’ logic written into it behind the screen or the clinicians are not consistent in their entries, it may not translate the data into a compliant medical record, Turner says.

For example, typically nurses assess wounds first. They take off bandages and measure and photograph wounds, entering the information into the EHR before the physician performs a surgical debridement. Suppose the nurse documented a 10 square centimeter wound as “75% red, granulated and healthy and 25% devitalized tissue.” The physician signed her note without reading it and then documented and billed for debriding 100% of the total wound size. “That generates a ridiculous conflict,” Turner says. “Since they only get paid per square centimeter of the area debrided, that could contribute to an overpayment. This happens everywhere. Clinicians think the documentation system is doing it for them in a compliant manner, but it paints them into a corner.”

At one wound care clinic, a physician seemingly performed 39 separate excisional muscle debridements on a mastectomy wound. “If you debride that much muscle in the outpatient setting, you have a bigger problem. That patient should have been in surgery or something else is going wrong,” Turner says. “When something doesn’t add up from a clinical standpoint, it may be the manner they have documented things.” This patient’s encounter notes were probably copied and pasted from previous encounters into subsequent visits or automatically rolled forward, she says.

**Outpatient Codes Are Tricky**

Hospitals also face challenges with new codes for wound care on the outpatient side. The CPT 2011 update changed the definition of CPT codes 11042 to 11044, which describe wound debridement for injuries, infections, wounds and chronic ulcers. CPT 11042 is “debridement, subcutaneous tissue” (which means skin), 11043 is “debridement, muscle and/or fascia,” and 11044 is “debridement, bone,” which includes the skin and muscle along the way. Medicare pays equally for skin and muscle debridement, but far more for bone. Coders report debridement according to the depth of the tissue that’s removed, not just exposed, and by the surface area of the wound. CPT codes 11042 to 11044 include debridement of the wound’s first 20 square centimeters, and there are three add-on codes for additional increments of 20 square centimeters (11045 for skin, 11046 for muscle and 11047 for bone).
Also, effective Jan. 1, 2012, the CPT book deleted 24 skin biologic and skin-substitute codes and replaced them with eight new application codes (15271-15278). The old codes were linked to products, Turner says, while the new codes are grouped by the size of the wound and the location on the patient’s body. Skin-substitute products will still have unique HCPCS codes to identify them, but they must be used with the eight new codes.

“It’s a cleaner way to do it but, it requires a radical shift in the way coders think. You have to do more math,” Turner says. “You may have four or five wounds to treat during an encounter. You have to think of which product, how much did I place on the patient and where.” Skin substitutes are considered a drug/biologic, so any part of the sheet that’s discarded must be reported to Medicare as waste. It boggles the mind quickly. Skin replacement comes in sheets of 44 square centimeters, and once the patient needs more than 99, “you jump up and use another set of codes.”

Wound care also can trip up hospitals because it’s subject to “repetitive billing.” When certain services are provided repeatedly during a 30-day period, Medicare allows hospitals to lump them on one claim. But MACs increasingly want expensive therapies and modalities to be reported on the claim with a primary code (using specific ICD-9 codes) to ensure they correlate to the patient’s problem and Medicare coverage, Turner says. That causes problems for hospitals when multiple services are provided in the same month and their primary diagnoses vary because the hospital UB-04 claim form has only one primary-code box available. For example, LCDs are written to cover hyperbaric oxygen therapy only if the wound is diabetic — not for venous or other pressure ulcers — “so we want to make sure diabetes (ICD-9 code 250.80) is listed as primary on the claim,” she says. However, the same patient in the same 30-day period may also receive another modality that is only covered if the ICD-9 code for ulcer (707.15) is listed as primary on the claim. But hospitals may be unaware that coverage hinges on the order of diagnoses. Even if all the codes are accurate and all the services are provided, MACs may deny the claim if the primary diagnosis code doesn’t support all the services on the claim.

Chargemasters Can Create Problems

Revenue codes invite problems for wound care as well. Four-digit revenue codes indicate where the patient received the treatment in the hospital. All CPT codes on the Medicare claim forms must be linked to a revenue code, Turner says. Information gleaned from revenue codes affects Medicare reimbursement to hospitals through the cost report.

Revenue center codes are listed on the chargemaster, which is the hospital’s master list of goods and services, with prices and codes. But wound care centers don’t have their own revenue code, Turner says. Most services performed there are reported with the revenue codes for clinic or treatment room (0761 and 0510). Unfortunately, hospitals often attach the wrong revenue code to wound care services, Turner says. For example, chargemaster coordinators may mistakenly assign the surgery revenue code to excisional debridement because it’s a type of surgery, or assign the revenue code for the physical therapy department to nonexcisional debridement, which may be performed by physical therapists. Both are wrong, and both affect hospital reimbursement through the cost report.

In fact, revenue codes aren’t the only way that your chargemaster may be causing you problems in the wound care arena. “Your chargemaster should be so clean and tight because
that baby is the heart. So many problems begin with a poorly built and maintained chargemaster,” Turner says. One client had a chargemaster that listed the skin substitute codes deleted in 2012. “No matter how well-documented and coded the services were, none will be paid if coded incorrectly,” she notes.

To improve wound care center compliance and revenue, Turner recommends routinely gathering people — including clinic managers, billers, coders, registration, compliance — for talking and training. “They are the most fruitful meetings,” she says. When hospital departments are islands that don’t understand how their piece of the puzzle affects the puzzle itself, “it’s a quiet killer,” Turner says. ✧

As OIG, RAC Recoupment for Drug Units Pile Up, Predictive Modeling May Bring Relief

Outpatient drugs are a favorite target of Medicare auditors, who are focusing on errors in the number of units billed. In the last three months of 2011, OIG identified half a million dollars in overpayments at 10 hospitals, while RACs also continue to hammer away at units of drug billing.

Hospital problems stem from the disconnect between pharmacy information and billing systems as well as the inevitable mishaps when translating medication doses to billable units, as required by Medicare.

“There are literally hundreds if not thousands of hospitals potentially at risk,” said Randy Wiitala, a vice president at Panacea Health Solutions, at a March 27, 2012, webinar sponsored by RACmonitor.com. “In all these cases, it didn’t matter which drugs were analyzed. All errors related to the incorrect application of billing-unit multipliers or units by billing systems or a mix of manual and automated interventions. Overpayments can pile up very quickly because the errors repeat themselves.”

OIG and CMS are using advanced data analysis techniques, such as predictive modeling, to identify drug-billing errors. “If we are not thinking along those lines as providers, we are already behind the curve,” Wiitala said.

Complying with Medicare billing rules for outpatient drugs “equates to patting their head and rubbing your stomach at the same time,” Wiitala said. Hospitals and physicians report outpatient drugs with HCPCS codes, which specify the dose. When hospitals administer a larger dose than represented by the HCPCS code, they use a multiplier to capture the correct amount. For example, if the HCPCS descriptor of a drug is 50 mg but 200 mg are administered to the patient, the hospital should bill four units. In other words, billing is based on the unit of measurement in the HCPCS code descriptor — not the packaging size or method or stocking method, said pharmacist Gary Fong, senior vice president of Panacea, who also spoke at the webinar.

Hospitals also must use the drug’s National Drug Code (NDC) to properly charge Medicare, Wiitala said. Each NDC represents the name of the drug, its strength, who manufacturers it and how it is packaged. “It’s universal and it’s how insurers make payment,” he said. Medicare provides a crosswalk from NDCs to HCPCS drug codes to help hospitals arrive at the accurate number of billable units administered to the patient. For example, the drug leup-
rolide acetate for depot suspension crosswalks to eight different NCDs. If hospitals don’t pay attention to these differences, it can interfere with their revenue streams in a big way, he said.

**Medicaid and Other Payers Will Follow**

“Not only does Medicare care about billable units, but we are seeing an extension so Medicaid and other payers use the same coding systems,” Wiitala said.

If the dose is not a multiple of the HCPCS code, hospitals should round to the next highest unit, Fong said. For example, with the anti-nausea drug Ondansetron, the HCPCS code J2405 represents one milligram. If the dose prescribed is a half milligram, hospitals still bill for one unit because they are supposed to round up to the nearest minimum,” Fong said. “You can’t bill a fraction of the unit, so if 1.5 milligram is administered, you bill two units.”

It can get very complicated — and some hospitals apparently make a lot of mistakes. Wiitala cited six of the drugs that are vulnerable to billing-unit errors, which “pop up over and over again” in OIG audits:

1. **Epoetin alfa is an injectable drug used to treat anemia.** Medicare requires providers to bill one service unit per 1,000 units of epoetin alfa. The HCPCS code is J0885, injection, epoetin alfa, for non-end-stage renal disease patients, 1000 units, according to OIG.

2. **Infliximab treats rheumatoid and psoriatic arthritis, ulcerative colitis, Crohn’s disease, and ankylosing spondylitis.** Providers bill one service unit for each 10-milligram injection of infliximab (J1745).

3. **Bortezomib is used for multiple myeloma and mantle cell lymphoma.** Medicare requires providers to bill one service unit per 0.1-milligram injection of bortezomib (J9041).

4. **Alteplase recombinant dissolves blood clots in blood vessels.** Providers bill one unit for every 1 milligram injection of alteplase recombinant (J2997).

5. **Alpha 1-proteinase inhibitor treats antitrypsin deficiency in people with emphysema symptoms.** Medicare requires providers to bill one unit for every 10-milligram injection (J0256).

6. **Immune globulin treats primary immune deficiency conditions.** Medicare requires providers to bill one unit per 500-milligram injection. The HCPCS code for this drug is J1561 and is described as injection, immune globulin, (gamunex), intravenous, non-lyophilized (e.g. liquid), 500 milligrams.

Errors in a few line items can trigger significant overpayments. “Many hospitals think they are protected if they are smaller facilities in rural areas,” but that’s not the case, he said. OIG can apply its data mining tools as easily to small as to large facilities.

In a March 8, 2012, report, OIG found significant errors in claims submitted by Bates County Memorial Hospital in Butler, Mo., for two injectable drugs, doxorubicin hydrochloride liposome and rituximab. The hospital “used the combination of an incorrect HCPCS code and the incorrect number of units of service” in six of seven line items billed to Medicare from Jan. 1, 2008, to April 30, 2011, according to the report (A-09-12-02009). The hospital has already refunded the $58,560 overpayment and taken corrective actions, the CEO said in a letter to OIG. For example, the hospital trained its revenue-cycle employees on pharmacy billing procedures and hired an accounting firm to review and revise its chargemaster, the CEO wrote.
In another recent audit, OIG identified almost $99,000 in Medicare overpayments for two drugs to 49-bed Central Peninsula General Hospital in Soldotna, Alaska. Three of the line items were for doxorubicin HCl liposome injections and 22 line items were for paclitaxel injections. Instead of billing five to seven service units of doxorubicin, the hospital billed 50 to 66 units, OIG said, and instead of billing five to 11 units of paclitaxel, the hospital billed 115 to 275 units. In response, Central Peninsula General Hospital told OIG it refunded the overpayment. The hospital also reviewed all J coded drugs to verify that the multiplier in its system represents the amount of medication dispensed to patients, and will conduct quarterly audits.

Meanwhile, all four RACs continue to hit billable units of outpatient drugs. Two biggies are Oxaliplatin, a chemotherapy drug, and Neulasta, which helps prevent infection in chemo patients. RACs use automated reviews to identify errors for billable units.

Wiitala described three steps hospitals can take to reduce the risk of errors and audits:

1. **Review billable-unit guidelines, including the Medicare Claims Processing Manual section on the definition of units (Chapter 4, Sec. 20.4) and reporting HCPCS codes (Chapter 17, Sec. 90.2.A).** The CMS website also updates the NDC-to-HCPCS crosswalk tables, which describe billable units as they relate to HCPCS codes and NDC numbers. “The data from CMS must be correctly interpreted and applied in the hospital billing system and must correlate with the HCPCS code and the dosage given to the patient,” Wiitala said.

2. **Validate your claims to confirm that the number and type of drug units associated with the HCPCS code are calculated correctly.** The number of units should exclude drugs that are prepared but never used (i.e., a patient’s condition improved) and not reflect the total amount in the vial, although Medicare allows billing for “wasted” drugs in single-use vials. This can be easier said than done because there’s often a disconnect between pharmacy information systems and billing systems, Wiitala said. He suggests the use of computer matching programs to align pharmacy and billing data. Also, stay on top of any changes. For example, before 2012, hospitals used C9280 to report one milligram of the injectable version of the drug Halaven (eribulin mesylate). But effective Jan. 1, 2012, hospitals now use J9179 to report Halaven 0.1 milligram. “We went from one billable unit to 10 billable units,” Wiitala said.

3. **Use predictive modeling, like the government does, to flag potential errors.** Since June 30, 2011, CMS has been streaming all Medicare claims through software as “an adjunct to human intelligence,” Wiitala said. The predictive modeling system builds profiles of providers, networks, billing, and beneficiaries and then develops risk scores to identify suspicious billing patterns. Hospitals can develop their own claim audit rule dictionary for billable units and adapt it for compliance monitoring. Here’s an example of one hospital’s rule focused on a specific drug:

   - **Drug:** Alimta 100 mg and 500 mg vials (J9305).
   - **Rule objective:** to assess drug units and price for reasonableness, potential OIG or RAC exposure.
   - **Select probability:** coding issue with moderate probability of affecting payment.
   - **Qualifying conditions:** Evaluate drug units, coding and price reasonableness with respect to unit cost and discharge.

   “You create a database that allows you to extract claims and build your own rules engine to examine claims for these types of occurrences,” Wiitala said.
Facing RACs: Strategies for Success

Greater Scrutiny, Use of PEPPER Data Will Reduce RAC Risks

With RAC recoupments skyrocketing in recent months, hospitals may want to drill down into billing data from CMS’s Program to Evaluate Payment Patterns Electronic Report (PEPPER). CMS uses RAC findings when deciding the content of “PEPPERs,” which are hospital-specific reports on billing for admission necessity and coding. While PEPPERs are free, the reports may wind up on the cutting-room floor before compliance officers get their hands on them. And even if compliance officers or auditors access PEPPERs, they may not make the most of them.

PEPPERs cover 29 target areas for short-term acute-care hospitals. Nearly every hospital receives PEPPERs, which show how their volume of billing in the target areas compares to other hospitals in their state, in their Medicare administrative contractor (MAC)/fiscal intermediary (FI) jurisdiction, and nationally. If there are billing outliers, it’s up to the hospitals to determine whether they translate into over (or under) payments or there’s some logical explanation.

Compliance Officers Should Seize PEPPERs

PEPPERs are generated by TMF Health Quality Institute, a CMS contractor. The admission necessity target areas include syncope, two-day stays for cardiac arrhythmia and 30-day readmissions. The coding target areas include septicemia, ventilator support and unrelated operating room procedures; the latter two are the top issues for two RACs.

“I suspect there are still people out there who know about PEPPER but don’t use it. They may not realize what type of resource it might be,” said Kim Hrehor, project director at TMF, in May 2011. The biggest challenge may be in compliance officers getting their hands on PEPPERs. QualityNet — a secure CMS server used by hospitals to report data for Medicare’s Internal Quality Reporting (IQR) program — is the only CMS-approved method to electronically distribute PEPPERs. Because all short-term acute care hospitals must participate in IQR, they all have a QualityNet administrator who is likely to be the person who sends in quality data to Medicare, Hrehor says. The problem is, when PEPPER data comes from TMF on QualityNet, the administrator may have no idea what it is. “These people get the report and don’t know what it is and just dump it,” she says. Compliance officers should get their own QualityNet account to ensure they receive PEPPERs. Hrehor suggests asking the QualityNet administrator at their hospital to set it up.

Although the comparisons in PEPPERs come in three flavors — state, MAC/FI jurisdiction and national — the national ranking is the most important in terms of compliance monitoring, Hrehor says. “While both the jurisdiction and national percentiles are important to consider, if you are an outlier compared to the nation, that is something you should sit up and look at because the nation is the largest comparison group,” with 3,400 short-term acute-care hospitals.

PEPPERs flag when a hospital is at or above the 80th percentile in any risk area, which means it submits a higher percentage of claims for that target than 80% or more of the hospitals in that MAC/FI jurisdiction. PEPPERs also alert hospitals when their percent of claims for
a coding-related risk area is lower than all but 20% of the hospitals in the MAC/ FI jurisdiction, which could mean underbilling.

“We encourage hospitals to use the national [benchmark] as the highest priority,” Hrehor says. As they prioritize internal reviews, hospitals should consider the reimbursement implications because program-integrity contractors tend to focus on high-value targets. “If you are in the top 20%, that is more an indication of being [an outlier] than if you are in the top 20% of, say, 300 hospitals in your MAC jurisdiction.” Plus, the jurisdiction comparison group may reflect regional differences in practice patterns that are not pronounced in the national comparison group.

When hospitals get their PEPPERs, Hrehor recommends they look at the Compare worksheet first. “That’s the heart of PEPPERs because it’s the only place where hospitals can see at a glance all the target areas for the most recent quarter and whether they are an outlier in any of them,” she says. The Compare worksheet also shows hospitals how many discharges occurred and how much money in total they received that quarter for each risk area.

**It’s All in the Math**

Understanding what the percents and percentiles mean is important. In calculating the percents, the numerator is the total number of claims your hospital submitted that quarter in a particular risk area, such as medical back problem MS-DRGs. The denominator is based on the same claims during the same period, but TMF uses a bigger piece of the hospital billing pie. “The denominator is a larger reference group we use to calculate a percent for the target area,” Hrehor says.

Take the example of an admission-necessity target that’s been a long-time risk area: one-day stays for chest pain and atherosclerosis. The numerator includes patients discharged in one day with MS-DRGs 313 (chest pain), 302 (atherosclerosis with MCC) and 303 (atherosclerosis without MCC). The denominator includes all patients discharged with any of these MS-DRGs regardless of their length of stay.

Then TMF divides the numerator by the denominator and multiplies that figure by 100. The result is a percentage that represents how many of your hospital’s claims for MS-DRGs 313, 302 and 303 are one-day stays. On its face, that’s not necessarily a bad thing. The next step, calculating percentiles, takes hospitals a lot closer to finding out whether they should audit the target area for overpayments. After TMF gets percentages for all 3,400 short-term acute care hospitals in this target (and the other 28 targets), it ranks them from smallest to largest in each comparison group (nation, jurisdiction, state). If 80% of the nation’s hospitals have a lower percent than your hospital for one-day stays for chest pain and atherosclerosis (i.e., your hospital’s percent is greater than 80% of all hospitals in the nation), consider pulling medical records and finding out why. There could be a physician with a penchant for admitting every chest-pain patient regardless of Medicare and InterQual guidelines, and that means potentially a lot of overpayments. But it’s possible that for most of those patients there’s a reasonable explanation, such as the opening of a nearby nursing home, which attracts many new patients with multiple serious conditions who may warrant admissions. PEPPERs just point you in the direction of questionable claims; they don’t equate with overpayments.

The coding ratios work a little differently. With septicemia, for example, the numerator includes the number of discharges for MS-DRGs 870, 871 and 872. MS-DRG 870 is septicemia
and severe sepsis with mechanical ventilation 96+ hours; 871 is septicemia and severe sepsis without the vent but with major complications and comorbidities (MCC); and 872 is septicemia and severe sepsis without vent or MCCs. Because a diagnosis of urinary tract infections (UTI) may have been upcoded to septicemia or severe sepsis, the denominator adds MS-DRG 689 (kidney and urinary tract infections with MCC) and 690 (kidney and urinary tract infections without MCC) to the septicemia and sepsis MS-DRGs.

Even though septicemia is a coding risk area, Hrehor encourages hospitals to contrast the patients’ lengths of stay in the numerator and denominator. Patients in the numerator theoretically would have a longer length of stay than patients in the denominator because septicemia is more serious than UTI and kidney infections. Compliance officers can ask the health information management or information systems departments to run a list of patients who were discharged with 870, 871 or 872 and look at lengths of stay for those patients and do the same for DRGs 689 and 690. “You expect patients with septicemia to have a longer length of stay,” especially if they are on a respirator for four or more days, she says.

RAC Extrapolation May Not Be Too Far Off; Process Requires Hospital Oversight

CMS has not approved the use of extrapolation for any RAC reviews, according to the top RAC official at CMS. But providers should prepare for it. “CMS believes extrapolation may be beneficial in situations where there is a high error rate and complex review is necessary, but the amount of the claim makes it not cost effective to review,” Connie Leonard, director of the CMS Division of Recovery Audit Services, told AIS in May 2011.

RACs have an incentive to extrapolate audit findings to a larger claims universe, since they could receive their full contingency fee for overpayments stemming from extrapolation, says Robert Jacobs, president of Health/ROI, a consulting firm in Lake Success, N.Y. However, it’s unclear when RAC extrapolation might happen.

Despite rumors to the contrary, no RACs have asked CMS for permission to use extrapolation. As a result, Leonard says, “I do not have a timeframe for when it might be used though it is something CMS has made available to the recovery auditors.”

Because providers are subject to extrapolation in other Medicare audits and will probably face RAC extrapolation at some point, hospitals should keep a close eye on the quality and fairness of extrapolation and the random sampling that’s at the heart of it.

The perils for providers are clear, since overpayment demands could grow exponentially with extrapolation, say Jacobs and Ellen Scott, director of appeals management for Health/ROI. But hospitals and other providers would have to appeal the claims denials on a case-by-case basis, even though they were denied en masse, according to Jacobs and Scott. “You have to fight each case,” Scott says. Even if a hospital wins every appeal stemming from the RAC extrapolation, Medicare may have already recouped the reimbursement during the potentially long fight to get it back. “It’s like a hedge fund borrowing money,” Jacobs says.

Auditors use extrapolation to project their audit findings from a small sample of claims to a larger universe instead of conducting a claim-by-claim review. “If you have 1,000 claims in the universe, you look at 10% of them. If you find a 50% error rate, you extrapolate that to the rest
of the population of claims instead of auditing the entire universe of claims,” Jacobs says. In some cases, a provider may make an administrative decision not to appeal low-dollar denials. It is unclear if such “accepted” denials could spawn a high-error calculation and a potential extrapolation issue, Scott says.

Before RACs can start extrapolating audit results, CMS must specifically approve their sampling methodology, says Fort Lauderdale attorney Lester Perling, with Broad and Cassel. RACs probably will use the same methods as other auditors, such as Medicare administrative contractors (MACs) and zone program integrity contractors (ZPICs), he says. Medicare auditors typically use “RAT-STATs,” which is software designed by the HHS Office of Inspector General to help choose random samples and evaluate audit results.

“The critical thing for providers will be to evaluate the sampling process the RACs use to ensure it is valid, the results are valid, and that the documentation is preserved so sampling can be validated and the results can be replicated,” Perling says. Auditors are required to extrapolate apples from apples and not apples from a mix of apples and oranges. That means some random samples will be straightforward and some will be “stratified.”

For example, primary care physicians perform a predictable set of evaluation and management (E/M) services, and therefore the results of an audit on a small sample should apply to a larger universe because their claims are comparable, Perling says. But the same wouldn’t apply to a surgeon, who performs both E/M services and procedures. “They shouldn’t be lumped together in one simple sample,” he says. The surgeon’s claims should be divided into separate samples for E/M services and procedures (and perhaps subdivided by procedure types). Extrapolation is separate for each sample, Perling explains.

**Strategies to Deal With Extrapolation**

Here are Perling’s tips for oversight of extrapolation and random sampling by Medicare auditors generally and RACs specifically. Some of this will require help from a statistician, he notes:

◆ **Get your hands on the auditor’s documentation of its random sampling and extrapolation.** **Auditors are re-quired to retain this documentation so providers can subject it to scrutiny by outside experts.**

◆ **Verify that samples** are randomly selected.

◆ **Verify the sample size** is sufficient to be representative of the universe.

◆ **Determine whether the sample** needs to be stratified. Then find out whether it was or wasn’t stratified.

◆ **Verify the calculations** used by auditors when extrapolating.

◆ **Compare the RAC’s extrapolation process** to the Medicare Program Integrity Manual guidelines on the subject. The manual “addresses how sampling studies should be conducted and documented, because RACs should be held accountable for that,” Perling says.

◆ **Check for “basic sampling errors** and how they were dealt with by the RAC,” he says.

◆ **Have your attorney study** existing sampling decisions from the Medicare Appeals Council, which is the highest HHS administrative appeals body. Certain decisions can be found on its website at www.hhs.gov/dab/divisions/medicareoperations/macdecisions/mac_decisions.html.
There are still fundamental concerns about extrapolation and the RACs, Jacobs says. When the RAC program was created, Congress said in Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that a RAC may not use extrapolation to determine an overpayment amount “unless the Secretary determines that: (1) there is a sustained or high level of payment error; or (2) documented educational intervention has failed to correct the payment error.” However, he says CMS has never defined a “sustained or high level of payment error,” and there is a desperate need for clarification in the RAC scope of work.

“While the authority for CMS using extrapolation (CMS Ruling 86-1) is apparent, the methodology and process remain ill-defined, leading to provider anxiety about their potential fiscal exposure and rights of response,” Scott says. “Hopefully, without bright yellow lines,” the RACs as well as CMS will proceed cautiously. ♦

RAC Letters Are Shifted to MACs in Bid to Solve Lateness Problem

Medicare administrative contractors (MACs) will soon take over the job of informing providers when recovery audit contractors (RACs) have concluded that certain overpayments exist. MACs will send “demand letters” to providers that state the results of RACs’ automated reviews.

“This change will eliminate providers getting late or untimely demand letters because the demand letter will automatically be issued after adjustment by the MAC,” Connie Leonard, director of the Division of Recovery Audit Operations at CMS, told AIS in August 2011. The shift from RACs to MACs of demand-letter logistics takes effect Jan. 1, 2012.

The way it works now, there’s a lot of back and forth between RACs and MACs. RACs identify improper payments and pass along that information to MACs so claims can be adjusted. MACs subsequently let the RACs know the claim has been adjusted, which triggers RAC demand letters to providers. “This last step sometimes gets delayed, and CMS has heard from providers who get late demand letters,” Leonard says. With MACs taking over demand letters, CMS cuts out the middleman.

The RAC-to-MAC shift won’t affect the discussion period — an informal, pre-appeal opportunity for providers to change the RAC’s mind about an overpayment determination — and “providers will still get the reasons for denial from the recovery auditor,” she says.

The Change ‘Makes Sense’

Zoe Zimmerman, compliance audit coordinator for Holy Spirit Health System in Camp Hill, Pa., says the change makes sense because MACs are the contractors that actually adjust claims in response to RAC claims denials. But she is concerned that RACs won’t notify MACs in time to stop the wheels from turning when providers are successful during discussion periods.

“If we had a decision that was overturned, would the RAC notify the MAC in time so we would not have the money recouped?” Zimmerman wonders. Or will hospitals have to hound the MAC to get money back?
This is not just an academic anxiety. “I have some cases from March [2011] sitting at the RAC because there is a problem with the MAC getting it through the process,” Zimmerman says. “I don’t know why that’s happening.” When she calls the RAC, Diversified Collection Services, to inquire about the delay, the RAC says the cases have been forwarded to the MAC. Fortunately, the money isn’t recouped prematurely, “but it is still sitting in our books and we are wondering what is happening in our claims,” she says.

Role of Prepayment Audits, Documentation Grow as RAC And RAC-Like Audits Multiply

Recovery audit contractors and their mirror image, RAC-like auditors hired by Medicare Advantage plans to identify overpayments, are hitting some hospitals hard, with an emphasis on complex medical reviews.

At the same time, hospitals face more prepayment reviews from Medicare administrative contractors and from RACs in the upcoming demonstration project. With most RAC denials based on lack of medical necessity, the best defense for hospitals may be appealing high-dollar claims all the way to the top and beefing up their utilization review process, compliance experts said in late 2011.

Some hospitals are coping with slews of denials from RACs and RAC-like auditors for Medicare Advantage plans and in some cases Medicaid. For example, as of the end of November 2011, Bay Regional Medical Center in Michigan had 1,871 of its claims audited by CGI, the Medicare RAC, and HealthDataInsights, the RAC-like auditor for Blue Cross Blue Shield of Michigan’s Medicare Advantage plan, according to Compliance Officer Mike Jamrog. Almost all stem from complex medical reviews, with the emphasis on cardiac cases, Jamrog said Dec. 12, 2011, at a RACMonitor.com webcast. This is no anomaly. With about 20% of Medicare beneficiaries enrolled in Part C, hospitals are expected to face more claims denials from RAC-like auditors.

Of the claims reviewed so far, 80% got a clean bill of health, Jamrog says, so the hospital appealed 70% of the denials. “I have $2 million of claims in the appeals process, and well over 60% to 70% are cardiac-related,” he said in an interview with AIS. In the past two months, the Medicare Advantage RAC-like auditor requested medical records for 177 claims — exclusively cardiac cases — while the same was true for 90 of the 170 RAC requests, says Jamrog, who keeps his board informed of RAC denials and appeals with quarterly dashboards.

The hospital has plenty of grounds for appeal, he says. For one thing, RACs and RAC-like auditors are slamming some hospitals for inpatient stents and cardiac catheterizations on the grounds they should have been performed on an outpatient basis with observation. The problem with the denials, Jamrog says, is that RACs are applying current admission criteria to claims from two and three years ago. At that time, the hospital based admission decisions on guidelines from professional societies, such as the American College of Cardiology. “The standard of care then was if you came in for a stent after a cardiac catheterization, you were admitted to the hospital overnight,” he says. Things have changed since then — medical technology moves at the speed of light — and many patients can have stent surgery as outpatients. But Jamrog says the hospital’s site of service should be judged on the standards in place at the
time the claim was submitted. Instead, the RACs and RAC-like auditors are doing what he calls “retroactive denials,” he says.

Audits, Audits Everywhere

Another compliance officer describes an onslaught of RAC, RAC-like and Medicaid audits. “The thing that really strikes me is they are combining their audits,” says the compliance officer, who asked not to be identified. One insurer conducted simultaneous Medicare Advantage-Medicaid RAC reviews of critical care services, observation ancillary services, and psychiatric and rehabilitation stays, among other areas.

In mid-December 2011, the hospital got a letter from another payer investigating cardiac catheterizations and stent placement for both its Medicare Advantage and commercial insurance plans. It’s agonizing, she says, to spend so much time responding to these audits when the hospital is able to substantiate about 96% of the dollars that it’s paid. “It seems to me a 4% error rate should be acceptable,” the compliance officer says.

Hospitals that appeal cases often beat the denials. So far, Bay Regional has won 65% of appeals, without having to climb to the top of the appeal chain in most cases. But hospitals are burdened by the vagaries of two different appeals procedures — one for the RAC and one for the RAC-like auditors of the Medicare Advantage plan, Jamrog says.

With fee-for-service RACs, hospitals appeal denials to the MAC, then the qualified independent contractor, followed by the ALJ and Medicare Appeals Council. RAC-like auditors establish their own appeals processes outside the auspices of Medicare, he notes. Bay Regional’s RAC-like auditor gives hospitals 50 days to decide whether to appeal denials and, if they lose, another 20 days to appeal to a physician review organization. “That’s the last appeal,” Jamrog says.

The saving grace of appeals is why Jamrog has mixed feelings about participating in CMS’s new rebilling demonstration. CMS announced on Nov. 15, 2011, that it would allow 10% of

Dashboard: Reporting RAC Benchmarks to the Board

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| Effective Recovery Rate | — | — |
the nation’s short-term, acute-care hospitals to resubmit Part A claims for 90% of the allowable Part B payment when Medicare auditors determine patients met the requirements for an outpatient stay but not an inpatient stay, as long as hospitals sacrifice their appeal rights. CMS began accepting applications for the 340 or so spots on Dec. 13, 2011, and Bay Regional went for it, but Jamrog says he’s not sure the hospital will follow through. He’s concerned about the fate of baseless denials (e.g., when RACs reject admissions for procedures that were on the inpatient-only list at the time of claims submission but have since been dropped).

As it works appeals, Bay Regional has learned the importance of specificity in physician orders and documentation clarity. For example, “with physician orders, you need to be super complete,” Jamrog says. One of its appeals to an HHS administrative law judge involved a physician’s admission of an elderly woman from the emergency room. On the order, the physician wrote “admit to 5 East.” The ALJ asked “what is 5 East?” The hospital’s physician adviser explained that it’s a cardiac unit, and provided supporting documentation (e.g., monitoring strips). That satisfied the ALJ and the denial was overturned, but the ALJ noted that admission orders should be understandable to everyone — “admit as inpatient” or “place in observation” — even if they don’t know the hospital’s layout. Similarly, Jamrog says, physicians should document the who, what, when, why and where in language that reviewers can understand. What necessitates treating Mrs. Jones as an inpatient instead of an outpatient? Is it dangerous if she is discharged after 24 hours in observation? So far, Bay Regional has won most of the cases it appealed to the HHS administrative law judge, although there have been only about seven. He credits the hospital’s in-house physician adviser and case managers, who help make the case for the medical necessity of the admission based on the treating physicians’ documentation and related records.

In fact, documentation demands are getting more intense. MACs are issuing local coverage decisions specifying documentation requirements for physicians, says Steven Meyerson, M.D., vice president of Accretive Physician Advisory Service in Miami. “Some are getting very detailed,” says Meyerson, who spoke at a webinar sponsored by RACMonitor.com. “We are seeing more denials based on the lack of documentation even though there’s no question the procedure was medically necessary and the inpatient admission was medically necessary.”

For example, First Coast Service Options, the Florida-based MAC, published an LCD (32078) for major joint replacement that spells out the documentation required for Medicare coverage, Meyerson says. “They are trying to eliminate unnecessary surgery,” he notes. Before paying for hip and knee replacement, the MAC wants evidence that it’s medically necessary and that other avenues, such as physical therapy, have been exhausted. “They are looking for the severity of the arthritis, the severity of the pain, that the patient used a walker, and that activities were limited by the pain,” he says.

First Coast Options is probably the most aggressive MAC when it comes to prepayment review, he says. Seventeen MS-DRGs are now subject to scrutiny before payment, he notes. Although prepayment review is anathema to providers because it suppresses cash flow, Meyerson sees an upside. “There are fewer retrospective denials,” he says. Maybe it’s better not to get paid for claims that will be challenged later anyway. It avoids the push-me pull-you of medical record reviews and appeals, he says. Now that RACs are getting into the prepayment audit game in a new CMS demonstration, the benefits are worth considering. “They don’t have to look over their shoulder,” Meyerson notes, adding that physician and hospital
financial incentives finally will be aligned. If the RAC rejects claims up front, neither the physician nor the hospital will get paid. “That will motivate physicians to get their documentation in compliance with Medicare requirements,” he notes, helping hospitals in the process. If they appeal the prepayment denial, they will win or lose together.

**UR and Case Management = Best Defense**

Whether claims denials result from prepayment or postpayment audits, one of the best defenses against them is a strong case management function and utilization review committee, Meyerson says. Medicare conditions of participation require hospitals to have UR committees, but whether they are leveraged for better compliance and revenue is another story. UR committees are charged with implementing a UR plan that reviews services provided by the hospital and by physicians on the medical staff. Some hospitals outsource their UR committees to a local medical society or quality improvement organization, which requires CMS approval, he says.

A UR committee must have two or more physicians. The committee reviews admissions, lengths of stay and professional services, such as drugs and biologics, Meyerson says. Ideally, UR committees assess admissions early in the patient’s stay, especially when case managers report that a treating physician’s admission decision conflicts with admission screening criteria (e.g., InterQual). If treating physicians stand by their admission decisions and can make a convincing case, the UR physician may agree, Meyerson says. If not, and the treating physician won’t back down, a third UR committee physician serves as the tie breaker. “The UR committee is kind of a nerve center,” Meyerson says. “It has a role in ensuring compliance with the conditions of participation.”

But Jamrog questions how much UR committees can accomplish when physicians don’t suffer financial consequences for their medically unnecessary admissions and services. Although Bay Regional has a committee that meets every other month and Jamrog serves on it, the physicians generally act like he is crying wolf when he talks about program integrity. “They are concerned that their documentation adequately explains the care they provided. But do they worry about documenting their history and physical to meet the requirements of the RAC?” No, because they won’t lose the professional fee for their daily rounds if that part of the medical records isn’t complete, he says. With RACs focused mostly on hospitals, “doctors don’t have their skin in the game right now.” Jamrog expects that to change when physicians feel more pain from Medicare auditors. “The doctor who is nailed by the RAC will be the better one for improving all of their documentation.”

**With More Audits, Health Systems May Need a Centralized Response**

If it had just been facing RAC audits, Advocate Health Care in Oak Brook, Ill., might have continued its largely decentralized approach to defending against government audits at its 12 hospitals.

But as a slew of state and federal program-integrity contractors revved up their audit machines, it became clear to Advocate’s compliance department that a more coordinated, corporate response was necessary. After all, audits are flying in from RACs, Medicaid, Medicare...
administrative contractors and the comprehensive error rate testing (CERT) contractor, and zone program integrity contractors (ZPICs) and HHS Office of Inspector General (OIG) are waiting in the wings.

As a result, about nine months ago, Advocate’s compliance team, along with its legal, finance and revenue integrity departments, began developing the idea of a corporate-level “regulatory response support team” that would meet with approval from the senior management of Advocate, the largest health system in Illinois. “The idea is to formalize and coordinate what has been going on [at individual facilities] and to add more bodies” to improve the data analysis, communications network, and corrective action, says Corey Perman, an Advocate site compliance officer and legal counsel. “It takes a village,” he says.

It’s Hard to Make These Investments

But it isn’t easy asking senior management to spend money on something that doesn’t, on its face, generate revenue. You have to sell the concept and then produce the results, he says. “Times are tight. We need to be good stewards,” Perman says. “Our pitch has been if we are proactive now, it will be better for us down the road.”

Apparently the arguments were persuasive because Advocate’s senior leaders agreed that a regulatory response support team is worth funding. “This is not fully operational yet, but it has been green-lighted,” he says. It fit with the Advocate corporate philosophy of “systematizing” as much as possible across its 12 hospitals for the purposes of consistency and better compliance, quality and efficiency.

Advocate hospitals already have regulatory response committees that work on audit issues. The committees include case managers, RAC coordinators, coders, billers and other relevant staff. “They make sure that key site-specific issues and requests are being addressed and responded to. They also discuss issues specific to coding and care management in looking at the appropriateness of the care at the hospital or level of admission,” Perman says. But now there will also be a regulatory response team at the corporate level co-directed by the chief compliance officer and the director of revenue integrity.

The corporate regulatory response team will serve as an organizing force around common themes throughout the health system, with training and corrective action to reduce errors. “Now there is a name on the door,” he says, a conceptual door to a new place “where people are talking to each other more” and can troubleshoot, anticipate, identify and fix problems before and concurrently with the alphabet soup of auditors.

“Someone is responsible at both the corporate level and the site level to make sure nothing falls through the cracks,” Perman says. For example, if the OIG sends letters to six Advocate hospitals about the same type of error, “Hospital A’s answers shouldn’t be diametrically opposite from Hospital B’s answers,” Perman says.

In addition to ensuring there are site liaisons at the hospitals, Advocate will hire new employees, including a content specialist (e.g., MS-DRGs, medical necessity), a data analytics specialist, a government response/appeals consultant, and a risk assessment/corrective action consultant. “With this new team, we will be in a better position to look at audit concerns and say, ‘what is the real issue and what can we do to fix it?’”

Moving forward with the new team, the chief compliance officer will report to Advocate’s executive leadership and the board on “what the dollars are and where we saved and the is-
sues we identified,” Perman says. “The mentality is, in the long-term, we will be more efficient and more consistent. There will be an Advocate way of doing things.”

Advocate is working in other areas to make its policies and procedures more uniform. For example, the compliance department initiated a series of risk assessment surveys over the past 18 months in its hospitals to address key compliance questions and regulatory requirements. The compliance department focused on hospital emergency departments and utilization management in 2011 and, in doing so, identified areas for improvement by surveying and meeting with hospital directors and leaders in these areas. In the utilization management survey, compliance found that while every hospital had a comprehensive utilization management plan, there was inconsistency in the details. In response, “we are working with a group of physician advisers and care managers to create a standard utilization management plan that includes core terms under Medicare’s Conditions of Participation that every hospital can use,” Perman says.

**RAC Audit Problems Rear Their Head Again; Some Physicians Help With Claims Denials**

Hospitals are hitting more bumps in the road as they navigate recovery audits. Some say they lose time to glitches in the appeal process and the “he said, she said” between recovery audit contractors (RACs) and Medicare administrative contractors (MACs).

At the same time, hospitals continue to enlist the help of physicians in RAC denial management, with mixed results.

“I think the volume is so heavy that mistakes can potentially arise,” says Evan Pollack, M.D., senior medical director of Medicare appeals for Executive Health Resources in Newtown Square, Pa.

One problem stems from a change in the way appeal-filing deadlines are calculated. At least one MAC starts the countdown from the date on Medicare remittance advices, not demand letters. That cuts short the time hospitals have to prepare appeals, says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa. Remittance advices and demand letters both state the fate of claims — whether there is a partial or full denial and the reason why — but remittance advices are sent to hospitals electronically, which means they have an earlier date than demand letters and arrive faster. As a result, MACs are rejecting some appeals on the grounds that they missed the 120-day filing deadline based on receipt of the remittance advice, not the demand letter, she said in March 2012.

But it gets wackier from there. In December 2011, WellSpan appealed four RAC claims denials to its MAC, Highmark Medicare Services. The appeals were filed within 120 days of the date on the demand letters, as required. Dailey was surprised when the appeals were dismissed out of hand, and not for any substantive reason. Highmark said WellSpan missed the filing deadline because the clock started ticking the day it sent the remittance advice, not the demand letter. “A redetermination must be requested within 120 days of receipt of the initial determination date on the Medicare Remittance Advice or the Medicare Summary Notice,” the MAC stated in a Jan. 25, 2012, letter.
That was “out of the blue,” she says. WellSpan was in jeopardy of losing appeal rights based on the MAC saying that the clock on the filing deadline starts ticking when the remittance advice is issued. But that wasn’t all.

The MAC’s dismissal made no sense because it was based on December 2011 appeals. “We showed them the demand letter, where it stated that the appeal was due within 120 days of receipt,” Dailey says. The MAC agreed it made a mistake, Dailey said, but it needed time to change its processes “because the deadlines in their software are based on transmission of the remittance advice, not the date on the demand letter.” Instead of a happy ending, however, the MAC rejected four more WellSpan appeals based on the date of the remittance advice. “The demand letter is a pivotal document,” she says. “Everything in the RAC program says the demand letter starts the timeline.”

**MACs, Hospitals May Use Different Clocks**

A CMS spokesman says the clock for filing appeals starts running the day the demand letter or Medicare remittance advice goes out. “In fact, CMS adds five days mailing time to the appeal timeframe to account for the receipt of the demand letter,” he says.

But Dailey says there’s a distinction. Not only are remittance advices sent earlier than demand letters, they are sent to different people. To cope, WellSpan will reset all the timelines in its defense-audit software.

WellSpan now has to appeal the cases to the qualified independent contractor, arguing the cases were dismissed in error. If the hospital wins, then it can appeal the denials based on the reason for their denials. “None of this has to do with the substance of the cases,” she says.

Other problems are cropping up. Some relate to MACs assuming responsibility for demand letters from the RACs in January 2012.

An apparent delay in getting demand letters out is wasting precious appeals time, says Vera Phillips, compliance specialist at Olympic Medical Center in Port Angeles, Wash. Its RAC, HealthDataInsights (HDI), sends overpayment determinations electronically to the MAC, Noridian Administrative Services. Phillips figures it’s taking 10 to 14 days for demand letters to reach the hospital. Because the deadline for preventing recoupment pending appeals is 41 days from the date on the demand letters, hospitals lose the time that they seem to be languishing in a Noridian warehouse, she says. “I believe they are postmarked and run through the meter but not mailed because it doesn’t take 10 to 14 days to get to us.” Even worse, the hospital is experiencing recoupment with little warning. The RAC sends the MAC audit results electronically, but the RAC sends the hospital audit results by mail. Because Noridian receives the overpayment determinations before the hospital —and is efficient in this respect — the demand letters hit the hospital within a day or two of the RAC’s findings. “It gives us no time to even review to see if we care to disagree,” she says.

The RAC has thrown obstacles in her path as well. HDI informed Olympic Medical Center of numerous underpayments in 2011, but it hasn’t paid the hospital back yet and now Phillips is getting the runaround. Noridian said the claims were closed but HDI said they weren’t. “I was told they reversed the findings, but I haven’t seen any documentation to support that,” she says. In other words, sometimes hospitals get letters notifying them of underpayments, but then the RAC changes its mind and the MAC takes back the money.
Frustration, Confusion Are the Norm

Frustrated with all the confusion, on March 7, 2012, Phillips sent both the RAC and MAC 28 pages worth of paperwork documenting the unreturned overpayments, demand letters that were never received and “claims we have had no response on whatsoever” after sending in medical records. Hopefully, there will be some response, though it may take months. That’s how long it took the hospital to get interest back on 21 claims it was wrongly charged on demand letters that were never sent.

To survive defense audits, you have to be “tenacious,” Phillips says. It takes persistence and patience to track the requests, denials, appeal deadlines and results, and identify and resolve the snafus. A certain amount is out of a hospital’s control. HDI insists submissions were forwarded to Noridian, which denies having them, so Phillips keeps calling.

In a similar vein, while RACs allowed hospitals to specify the person who should receive demand letters, MACs don’t always extend the same courtesy, says Steven Greenspan, vice president of government appeals and regulatory affairs at Executive Health Resources. “It’s a game-changing event for providers because now they have to worry whether they got the demand letter,” he says. “There is a lot of follow-up for providers. Some MACs accept requests to send demand letters to a designated person at the hospital, Greenspan says, but they are not obligated to do this.

In addition to MAC and RAC snafus, some hospitals say it is an uphill battle to engage physicians in documentation improvement and denials management. But that picture is ambiguous. Some experts say physicians are frustrated when auditors declare their admissions medically unnecessary and willingly engage in appeals and compliance initiatives. Others say physicians are tired of all the regulatory and compliance demands, and focus only on what they perceive is important to patient care and their own reimbursement, which is not yet affected, for the most part, by hospital claims denials.

Dailey has found some physicians more responsive than others. For example, after WellSpan got a number of RAC denials for urinary and renal procedures, which is a big admission necessity issue, she met with the physician who managed the practice responsible for some of the denied procedures. They talked about the relative invasiveness of the procedures and complication rates. “He liked that we went over and talked to him about it,” Dailey says. As it turned out, the physicians had already changed their habit of admitting inpatients for urinary and renal disorder procedures. Instead, the physicians were now performing the surgeries on an outpatient basis with observation. Her interaction with this practice manager was a positive experience. And it was interesting because these physicians were not employees of WellSpan.

But that hasn’t always been Dailey’s experience. WellSpan decided to appeal one of the urinary-procedure admission denials to an administrative law judge. She asked the physician to attend the ALJ hearing to explain why he admitted the patient, but he got huffy. “The doctor wasn’t willing to help me appeal it,” she says. “He said, ‘who is Medicare to say I can’t do this in the hospital?’” The ALJ told WellSpan to be there on a Thursday, but the physician refused, saying he had procedures to perform. He never showed, but the end result was favorable for WellSpan anyway.
Sharing Data With Physicians Can Help

Sharing data with physicians may change their behavior. Show them how many cases were denied because of their missing or erroneous documentation and how much money was lost, she says. “It means something to them. It makes it more possible to get their buy-in,” she says. “It has to be concrete for them.”

It helps to say, for example, that “we had 487 medical records audited by the RAC and so many were denied and that means $2 million had to be given back,” Dailey says. That’s $2 million less for equipment that physicians want to buy.

But Pollack predicts it will always be an uphill battle, especially until physicians have a financial stake in denials. “The government would like nothing more than for hospitals and physicians to work closer and better and to support each other. That’s the logic behind ACOs. But there is a certain amount of mistrust,” he says. “Physicians may be less inclined to get involved because [denials of hospital claims] do not directly affect a patient’s care. They may view this more as a financial issue for hospitals.”

Medicaid RACs Are Gearing Up, but MICs Get Bad Marks in New Report

Medicaid RACs are now active in at least three states and are slowly gearing up across the country. Now that hospitals in New Jersey, South Carolina and Indiana have received requests for medical records from their newly minted Medicaid RACs, the next round of program-integrity games in March 2012 had begun.

The government has high hopes for overpayment recovery from the contingency-fee contractors, with projected savings of $630 million by fiscal year 2016 — a stark contrast to new findings that federal Medicaid integrity contractor (MIC) audits have largely been a bust so far.

“There’s lots of enthusiasm for how effective Medicaid RACs are expected to be,” says Atlanta attorney Sara Kay Wheeler, with King & Spalding.

But they are not the only Medicaid audit game in town. CMS is taking steps to make MICs more effective and pressing states to increase oversight of Medicaid managed care programs, while the OIG 2012 Work Plan has set its sights on “potentially excessive Medicaid payments for inpatient and outpatient services,” among other Medicaid targets.

Meanwhile, by statute, health care organizations must return Medicaid and Medicare overpayments within 60 days of identifying them, even though the proposed regulation interpreting that health reform requirement extends only to Medicare fee-for-service. And Sec. 6401(a) of the health reform law makes effective compliance programs a condition of enrollment for both Medicare and Medicaid; proposed regulations will hopefully be issued soon.

Medicaid RACs: New Kid on the Block

But the new kid on the block is Medicaid RACs, which were required by Sec. 6411 of the health reform law and were slated to be up and running on Jan. 1, 2012, according to the final CMS regulation published Sept. 16, 2011. That hasn’t happened everywhere yet, but 21 states had a Medicaid RAC contractor selected as of March 20, 2012, according to Paul Spencer, compliance officer for Fi-Med Management in Wauwatosa, Wis. A few states couldn’t get any
vendors to bid on RAC contracts, Spencer says. He speculates that while CMS allows a 12.5% contingency fee, some states may have laws capping it at a lower percent, scaring off potential suitors.

CMS requires some basic standards for Medicaid audits that clearly result from the learning curve associated with Medicare RACs, says Judy Waltz, with Foley & Lardner LLP in San Francisco. For example, each Medicaid RAC must hire a licensed doctor of medicine or osteopathy to act as the RAC’s medical director, and must hire certified coders. States will decide how many medical records they can request from providers and how often. Medicaid RACs must operate a toll-free customer service phone line during normal business hours and each Medicaid RAC must work with the state to develop an education and outreach program for providers that includes notification of audit policies and protocols.

States, not RACs, will report fraud to Medicaid fraud control units or other law enforcement, Wheeler said in March 2012.

There is a three-year look-back period for Medicaid RAC audits, Wheeler says. RACs are required to accept electronic medical record submissions from providers, and notify them of audit findings within 60 days, Wheeler says. It’s up to states whether RACs are permitted to do medical necessity reviews, whether to extrapolate findings into larger overpayment determinations and how to handle appeals, Wheeler says. New York City-based contractor HMS is turning out to be a big player in the Medicaid RAC game, and it has signed a contract with Milliman for admission-necessity screening criteria, Wheeler says. (HMS owns HealthDataInsights, a Medicare RAC.)

**Hospitals Should Start Networking**

And states decide whether to require Medicaid RACs to post their audit targets the way Medicare RACs do, she says. “I suspect it will be inherent in the contractual relationship,” she says. In the Indiana RAC program, Medicaid providers will be subject to Medicaid credit balance reviews, automated reviews and complex reviews, according to a February 2012 presentation by HMS and Thomson Reuters. The presentation states that the Indiana Medicaid agency will provide “final approval of the type of audits the RAC will deploy for each provider and/or audit project,” according to information from Wheeler. However, it’s unclear whether Indiana will require HMS, its Medicaid RAC, to notify providers and suppliers of approved audit issues before launching the audits, she says.

Medicaid RACs are required to review fee-for-service claims, Wheeler notes, but CMS has been less definitive about whether Medicaid managed care is fair game. In the final September 2011 Medicaid RAC rule, CMS did not exclude Medicaid managed care. Instead, it allowed states to make that decision. The states will look at what it would mean to have Medicaid managed care in the universe of audits. It’s unclear whether the audits would focus on how Medicaid managed care plans submit data to Medicaid agencies, or on payments to managed care plans or both. Either way, providers will be affected, Wheeler says, because ultimately managed care plans are a vehicle to pay providers.

Hospitals should be gearing up for Medicaid RACs. “Hospitals have been hit incredibly hard by Medicare RACs, and RAC coordinators in hospitals should talk to RAC coordinators in other states,” Spencer says. Because CMS does not require Medicaid RACs to post their audit targets, the Medicaid experience may require a lot of networking. Hospitals may have to scramble with Medicaid RACs even more than they do for Medicare RACs.
Early Assessment of MICs Is Not Favorable

Meanwhile, MICs got a bad report card. Congress probably won’t be too thrilled with OIG’s “early assessment” of the effectiveness of MICs that perform audits. According to a report released March 20, 2012, “few of the audits assigned to Audit MICs from January through June 2010 identified overpayments.”

OIG examined the results of the 370 audits assigned to audit MICs — which audit Medicaid claims based on leads from “review MICs” — and interviewed officials from CMS, audit MICs and state Medicaid oversight agencies. The results: 81% of the audits didn’t identify overpayments or are unlikely to. “Only 11 percent of assigned audits were completed with findings of $6.9 million in overpayments” — and 90% of it stemmed from “collaborative audits” (conducted with help from CMS, states and review MICs), according to the OIG report (OEI-05-10-00210).

So what was the problem? Audit MICs were “hindered,” OIG concluded, partly because “audit targets were poorly identified” and were often “inappropriate.” There were also problems with the Medicaid Statistical Information System (MSIS) data used in MIC audits, so sometimes audit MICs were sent on a wild goose chase. For example, they audited claims for services supposedly provided to patients after they died, but it turned out the dates of death were incorrect.

Given its findings, OIG recommends more collaborative audits, better selection of audit targets and perhaps the consolidation of review and audit MICs under one program integrity contractor. Also, MICs need access to more reliable data, and the review MICs should do a better job analyzing it. As OIG has said before, CMS should implement “T-MSIS,” a more advanced version.

In a written response, CMS Acting Administrator Marilyn Tavenner told HHS Inspector General Dan Levinson that CMS “has dramatically increased the number of collaborative audits assigned to audit MICs.” It’s also working on several fronts to improve data quality and selection. And “CMS is evaluating options for awarding new contracts to include consolidating certain tasks and requirements,” she wrote. ♦
Denials and Appeals

RAC Medical Necessity Audits Accelerate, But Hospitals Say Some Miss the Boat

As recovery audit contractors (RACs) move full speed ahead with medical-necessity reviews, they may deny claims without a full picture of the patient’s care, compliance experts said in summer 2011. RACs may deny admissions because a diagnosis or procedure is ripe for outpatient treatment, but patients don’t always progress predictably. In some cases, RACs deny claims for inpatient admissions because patients could have been treated in observation, disregarding the documentation that shows the patients were, in fact, treated in observation before they were bumped up to an inpatient bed, some experts say.

The tension between hospitals and RACs may intensify now that the number of medical-necessity audits is increasing. The percentage of hospitals experiencing RAC medical-necessity overpayment determinations rose from 84% to 93% between the first and second quarters of 2011, the American Hospital Assn. (AHA) says in an August 2011 report. CMS expects hospitals to place patients in observation unless they meet inpatient criteria as described in the Medicare Benefit Policy Manual. According to the manual, physicians should consider ordering inpatient care if a patient is expected to require hospital care for at least 24 hours, but “the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,” including the risk of something bad happening to the patient if he or she is sent home.

Hospitals are worried they won’t get a fair shake from RACs when admission is warranted, especially if RAC reviewers don’t consider the entirety of the medical record during admission-necessity audits. “They are not looking at the full admission on the patient,” says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa. “They are just looking at the history and physical.” The H&P — the heart and soul of a chart — includes the review of systems, chief complaint, past family and social history, and medical decision making. But the H&P doesn’t typically contain physician orders, which can make or break a medical-necessity case, so RACs shouldn’t limit the scope of their reviews to only the H&P, she says.

Renal Case Shows Observation Snafu

For example, the Region A RAC recently recouped an MS-DRG payment that WellSpan received for treating an 80-year-old woman with altered mental status. Her daughter brought her to the emergency department after noticing reduced oral intake and greater confusion during the previous four days. The patient was diagnosed with a urinary tract infection, given IV antibiotics and placed in observation on May 15, 2010, pursuant to the physician’s order. Ultimately, physicians diagnosed acute renal failure and upgraded her to an inpatient on May 16, 2011. The RAC, Diversified Collection Services, concluded that the patient did not qualify for admission and should have been treated in observation.

This felt Kafkaesque to Dailey because the patient was, in fact, treated in observation. Dailey pointed this out to the RAC when she submitted the medical records for review. Even if the
RAC never looked beyond the H&P, it dated back to May 15, 2011, a day before the admission, so the patient’s observation stay should have been clear to the RAC, and the hospital should not have been dinged for a short stay, she says. Instead, WellSpan has to invest in an appeal. Dailey says WellSpan makes its share of mistakes and accepts the RAC recoupment for them. But there are also plenty of unwarranted overpayment determinations, she says, and dealing with them eats up a lot of time.

Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia, has seen the observation problem elsewhere. “Unfortunately, when such denials are issued inappropriately, they may perversely penalize hospitals that are trying to do the right thing and appropriately use observation. When a patient is admitted to the hospital after failing to improve after a day or two in observation, the resulting stay may technically be considered a short stay, even though the patient has been hospitalized for several days,” Taylor says. These denials are troubling if documentation shows that the patient failed to improve in observation and needed prolonged or intensive medical care. Taylor thinks hospitals should be prepared to appeal cases if they believe that the RAC denied a medically necessary admission after documented failure of an appropriate period of observation services.

Connie Leonard, the director of the Division of Recovery Audit Operations at CMS, confirms that “one of the prevailing reasons for denial [of inpatient claims] is the incorrect place of service. This usually means the patient was admitted inpatient when it could have been outpatient or observation.” However, she hasn’t heard of RACs denying inpatient claims in favor of observation when the medical records showed patients were first treated in observation. If provided with examples, Leonard says CMS “would absolutely look into the issue to determine if it needed to be addressed.”

**RACs Are Skeptical of Syncope Admissions**

The bulk of RAC admission-necessity denials stem from short stays (one or two days), AHA says. RACs now are reviewing short stays for medical DRGs, such as syncope, transient ischemic attack and chest pain, and surgical DRGs, including urological and gynecological procedures, Taylor says. RACs continue to add MS-DRG targets that will be evaluated through the lens of admission necessity.

Hospitals tend to appeal overpayment determinations when they believe they have complied with Medicare medical-necessity guidelines. For example, RACs have denied a lot of syncope cases (MS-DRG 312) based on the premise it can be treated in 24 hours or less, the litmus test for observation.

“But they are not taking into account the comorbidities of the patient,” Dailey says.

If patients have a syncope or faint and there’s a history of cerebrovascular disease, prior heart attack or coronary artery disease, the hospitalist (with the ED physician’s concurrence) may order inpatient admission. They often are supported by InterQual admission-screening criteria, especially because it takes some medical detective work to determine the cause of sudden unconsciousness, Dailey says.

Though CMS announced in January 2011 that InterQual criteria are no guarantee that auditors will green-light an admission, Dailey says that “we are going with the premise that we are complying with the Medicare conditions of participation.” That means WellSpan has a utilization review committee to review physician admission decisions and case managers who...
screen a majority of admissions pursuant to InterQual. All this is explained to the RAC when it requests medical records. But the RACs give so little in return, Dailey says. In their letters, RACs state their denials are based on whether the “specific plan of care can be implemented and completed within 24 hours.…Even if the expected outcome were not reached within that time frame, the patient could have been safely admitted to inpatient status within 24 hours.”

Renal, Urological Admits Can Be Problematic

The RACs also are denying admissions for renal or urological procedures. While on their face, certain renal procedures, such as cystoscopies, should be billed as outpatient services, there are always exceptions — and RACs are required to read medical records closely enough to recognize this, Dailey says.

But that was not the case in a recent overpayment determination of an MS-DRG payment for a patient who came to a WellSpan hospital ED with left-flank pain, nausea, vomiting, shakes and chills. The patient was rushed to the operating room, where a nephrologist performed a cystoscopy (which allows a peek inside the bladder and urethra) and inserted a double J stent to relieve kidney stones. Though the surgeon said the patient probably could be discharged home later that day, the surgeon wrote an order for admission instead of observation because of fears the patient would become septic. “He had a UTI and some signs of sepsis and an obstruction,” Dailey says. In denying the claim, the RAC says the patient’s condition did not necessitate admission; cystoscopies can be rendered on an outpatient basis. That’s generally true, she says, but not in this kind of scenario.

WellSpan is appealing the renal-procedure case, but it has dispensed with the discussion period altogether. The CMS-mandated discussion period — the chance for hospitals to change the RAC’s mind before starting a formal appeal — may be futile for medical-necessity denials because RACs don’t seem to hear them out, Dailey and Taylor say.

Discussion Period Is Source of Confusion

Taylor said the discussion period worked better when hospitals were disputing coding denials. “The discussion period has not been as successful as providers hoped” for medical-necessity overpayment determinations. Unlike coding, medical necessity involves discussions about medical decision making and physician insight. “Since providers are no longer assured direct access to the RAC medical director, they do not have the opportunity to make the case as effectively,” Taylor says.

Leonard said she’s unaware of any complaints about the discussion period. But she notes this option is available only when new information is presented. “Sometimes providers send in a discussion request without any additional information,” Leonard says.

Appeals are a mixed bag. Hospitals aren’t faring well on the first few levels (e.g., redeterminations).

But hospitals shouldn’t give up when they believe their claims are correct, Taylor says. “Hospitals are still frequently failing to appeal or meet appeal time frames,” he says. “They are sometimes giving up early in frustration if they lose the first round of appeals.” He encourages hospitals to press on if their appeals have merit because eventually they will hit administrative law judges (ALJs). “You may find the ALJ hearing to be a more conducive forum for having your voice heard. ALJs take more time on the case, and they don’t use commercial admission screening standards as the only standard. They look at all the evidence.”
Across the country in Washington state, Olympic Medical Center just got word that its RAC, HealthDataInsights, Inc., denied 19 inpatient stays for lack of medical necessity. Compliance officer Mic Sager says the hospital is appealing eight of them. In response to the denials, the hospital has beefed up its admission screening process. Case managers will do utilization review seven days a week, up from five. They work 6 a.m. to 8 p.m., so a big chunk of the day is covered, he says. Before, if a patient was admitted Friday and discharged Saturday, no case manager was around to screen the admission up front or in time to recommend a change in status using condition code 44.

This is a challenging area for hospitals, Sager notes. “Inpatient medical necessity is really soft,” unlike medical necessity for outpatient lab tests, for example, which requires specific diagnoses to ensure Medicare coverage. Determining inpatient versus observation status “is so subjective,” he says. “There is no objective legal standard.” The appeals will be based on the fact that Olympic’s admissions met InterQual criteria.

MACs May Change Their Mind on Closed Cases, Sit on Money Too Long Post-Appeal

Tensions are growing between hospitals and Medicare administrative contractors over RAC appeals, as some MACs reopen closed cases, fail to repay hospitals in a timely manner and generally cross wires with RACs.

With all the disarray, hospitals may want to reconsider immediately returning overpayments stemming from RAC claims, a strategy to avoid paying interest while they appeal. As it turns out, MACs may take a long time to refund the money to hospitals that win appeals, which means the MACs are earning interest on hospital money while they drag their feet, compliance officials said in October 2011.

“The system is getting overwhelmed and I think that’s the problem,” says Fort Lauderdale attorney Lester Perling, with Broad and Cassel.

In more than one case, a hospital won its appeal of a RAC denial at the first level of appeal, which is called “redetermination.” The MAC, which handles redeterminations, gave the hospital its victory, but then took it away — reopening the case unilaterally and reviewing it again. This wasn’t an appeal of the redetermination; it was a second review of the same MAC decision months after the case was ostensibly resolved.

“It’s crazy — there has to be some kind of closure to this whole process,” says Colleen Dailey, clinical coordinator of defense audits for WellSpan Health in York, Pa.

In one of the cases, WellSpan’s MAC, Highmark Medicare Services, recently reopened a case and changed its mind after the hospital won an appeal. It stemmed from a claims denial by WellSpan’s RAC, Diversified Collection Services (DCS). The RAC downgraded a claim for MS-DRG 65 on the grounds that physician documentation did not support the coded complication/comorbidity. WellSpan appealed the denial to Highmark and won. In a Feb. 15, 2011, letter, Highmark said the appeal was “fully favorable to you.” But eight months later, Dailey got a letter from Highmark that knocked her socks off. Highmark told WellSpan that the decision was only “partially favorable” and therefore the claim is only partly covered by Medicare. “I can’t relay to you the frustration I feel about this whole thing,” Dailey says. “You can’t depend on their decisions.”
As it turns out, MACs are within their rights to reopen appeals decisions at the same level. “This is allowed, but it doesn’t normally occur,” says a CMS appeals official. “The timeframes and reasons for reopening redeterminations are the same as the rules for reopening initial determinations. Also, if a MAC reopens and changes a redetermination, it would be considered a revised determination with new appeal rights,” which means the deadline would be 180 days.

But Dailey wonders why they would review a closed case. What’s the criteria for reopening something that has purportedly been resolved? When can hospitals ever feel their accounts are reconciled? All of this is still unclear. Michigan attorney Drew Wachler says hospitals that are in this same boat may have to go higher up the food chain, to an HHS administrative law judge, if they don’t get a satisfactory answer from the MAC. “We need some guidance from these contractors,” Wachler says.

Other Problems Have Occurred With MACs

Hospitals have faced other problems with MACs in terms of their RAC claims denials, appeals and the fate of their funds, including getting refunds from MACs when they have won appeals.

When RACs deny claims, some hospitals always repay MACs immediately — even when they plan to appeal — in order to avoid paying interest. MACs don’t charge interest if hospitals return the money within 30 days. But sometimes their funds are held hostage when the hospital ends up winning the appeal.

WellSpan, for example, is trying to get back $81,000 from the MAC in the wake of RAC denials that were successfully appealed. Two of the cases date back to February 2011, two are from April 2011 and one each from July and August of 2011, says Wendy Trout, director of corporate compliance and revenue management. “We get no interest while they hold our money,” she notes. “We won. Why don’t we have the money back?”

Trout has gotten the runaround from the RAC and the MAC. The RAC says it sent the information to the MAC and that WellSpan will have to call there, but Highmark said it had no relevant information from DCS. She goes up the food chain and forwards proof to the MAC, but to no avail. While time drags on, the MAC is collecting interest on WellSpan money. “This has me wondering: Should we be evaluating each case and if we think we will win on appeal, not pay anything back and just wait for them to recoup it? Then when we win, they will pay us interest,” she says.

MACs also are required to suspend recoupment and interest charges when hospitals appeal RAC claims denials within 30 days. But Cahaba Government Benefit Administrators is ignoring that rule, says Tammy Calvert, RAC coordinator for Maury Regional Medical Center in Columbia, Tenn. “I had 30 accounts where I submitted a timely appeal, but [Cahaba] still recouped. They are not supposed to recoup” if the appeal is filed in 30 days, she noted. The MAC eventually refunded the money, but the letter she received explaining its corrective action lacked enough detail to sort out what exactly the MAC did — which accounts were rectified and how. “I am still working to get this resolved,” she says.

Highmark also has turned away appeals because of misinformation from the RAC. The RAC told Highmark that it reversed certain WellSpan claims denials during the discussion period. But Dailey was staring at a RAC denial letter when she got word from Highmark that it wouldn’t accept appeals because WellSpan supposedly won. “The RAC told us ‘not to worry
about it,’” she says. “You can’t depend on their decisions right now, and they are not forthright with their answers. It takes up a lot of time.”

Connie Leonard, director of CMS’s Division of Recovery Audit Operations, told AIS that she will look into certain problems if the hospitals will share details with her. Generally, though, Leonard says, “The recovery auditor should not be answering any questions about an official appeal. All appeals are handled by the MAC and any questions/decisions are completed by the MAC. All the recovery auditor does is give the case file to the MAC once an appeal is filed and accepted.”

Highmark declined to comment.

**Underpayments Are Also a Problem**

Underpayments are another area that raises eyebrows at hospitals. Sometimes RACs notify hospitals they were underpaid and will be credited. Because accuracy — not just minimizing overpayments — is the goal of compliance, hospitals review underpayment determinations as well. If documentation doesn’t support the RAC’s underpayment conclusion, hospitals should inform the RAC that it made an error and supply supporting documentation. But several hospitals say RACs will insist the hospital was underpaid.

Leonard says when RACs argue hospitals are owed underpayments, they can appeal the finding to the MAC. “I don’t think it would take more than an appeal to the MAC,” she says. Still, hospitals are frustrated they have to lodge appeals to compel MACs to take their money back.

Perling says these and other hiccups hint at some chaos in the program-integrity world. The “logjam” will continue “until someone sues or something dramatic happens” he says. Perling says he has had a decision pending before an ALJ for five months. Because it was taking so long, “I asked for an escalation to the Medicare Appeals Council and they didn’t respond,” he says. If MACs don’t render decisions in the mandated time frame — 90 days from the date the appeal is submitted — providers can try to speed things up by asking to go straight to the Medicare Appeals Council, Perling says. At some point, providers want to send the message to the MAC and ALJ that they can’t wait forever to resolve payment disputes.

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**CMS Opens Door to Rebilling Inpatient Denials; RACs to Start Prepayment Reviews**

Hospitals are inching their way back to full-fledged outpatient reimbursement for inpatient claims denied by Medicare auditors because the patient could have been treated in a less intensive setting.

CMS announced on Nov. 15, 2011, a demonstration project to allow “rebilling” at about 10% of the nation’s hospitals, though hospitals have already made headway on this issue through appeals. Administrative law judges (ALJs) generally agree that hospitals should be able to resubmit a Part A inpatient claim to Part B if it’s denied solely based on the site of the service — an inpatient bed — and not the service itself, says Washington, D.C., attorney Don Romano, former director of the CMS Division of Technical Payment Policy.

The rebilling demonstration is one of three unveiled as part of CMS’s ongoing initiatives to reduce fraud, waste and abuse. The second demonstration allows RACs to start prepayment

Rebilling is a big issue for hospitals because it’s their chance to survive the financial damage of certain Medicare medical-necessity denials. Rebilling was permitted under the three-year RAC pilot (2005-2008) but then forbidden when RACs went national under the permanent program. That policy change turns medical-necessity denials for inpatient stays into almost a total loss for hospitals.

When RACs deny inpatient stays as medically unnecessary, hospitals are not permitted to shift the claim to the APCs under the outpatient prospective payment system. They can bill Part B for ancillaries provided to the patient during the hospital stay, but that’s a drop in the bucket compared to outlays for inpatient care. As a result, hospitals have spent two years lobbying CMS to allow rebilling so they can reclassify inpatients as outpatients in the wake of medical-necessity denials. Things didn’t look good, however, after Connie Leonard, director of CMS’s Division of Recovery Audit Operations, said in 2010 that rebilling under the national program requires a change in the law.

Now CMS has nudged open the door to rebilling with the demonstration, which is not limited to RAC denials. It applies to Part A inpatient denials by a Medicare administrative contractor, RAC, or the comprehensive error rate testing (CERT) contractor. If they participate, hospitals can resubmit claims for 90% of the allowable Part B payment when the auditor determines that a Medicare patient met the requirements for Part B services but not for an inpatient stay. Beneficiaries won’t be held responsible for any resulting changes in coinsurance.

A “representative sample” of 380 hospitals nationwide will participate and everyone’s invited to volunteer. CMS says the demonstration “is expected to lower the appeals rate, which will protect the trust fund and reduce hospital burden.”

Hospitals have to weigh the pros and cons of volunteering for the demonstration, says Romano, who is with Foley & Lardner LLP. On the one hand, the rebilling option is very desirable for obvious financial reasons and spares hospitals the burden and expense of appeals. On the other hand, hospitals are already besting the rebilling ban through appeals. “They have won every ALJ or Medicare Appeals Council appeal in every single case I know of” where Part B reimbursement was sought after a Part A denial, says Romano. On top of that, CMS pays hospitals only 90% of Part B reimbursement for rebilled claims under the demonstration.

Romano has doubts about CMS requiring congressional intervention to permit rebilling on a permanent basis. “If there is a legal prohibition for paying hospitals under Part B when they file claims under Part A, as CMS suggested, then how come [Medicare] pays them for Part B ancillaries?”

CMS’s recognition of the rebilling problem is appreciated, but hospitals should focus on improving inpatient orders and fight for the right to rebill across the board, says Royal Oak, Mich., attorney Drew Wachler. “It’s important for hospitals to continue to push for reimbursement and to make appropriate arguments on appeal and establish this right [to rebill Part B] independent of the demonstration,” he contends.

If hospitals want to rebill under the demo, they should move fast, Romano notes, because CMS is accepting applicants on a first-come, first-served basis. However, it’s unclear whether the demo — which starts Jan. 1, 2012 — applies only to claims denied after that date or to any
denied claims for which an appeal is pending or for which the time to appeal has not yet run out, he says.

**Pilot Announced on RAC Prepayment Reviews**

CMS also announced a pilot program to let RACs conduct prepayment reviews. MACs and zone program integrity contractors (ZPICs) already do prepayment reviews, but RACs are strictly postpayment auditors. Now, however, under the Recovery Audit Prepayment Review demonstration, RACs will review select claims to determine whether the provider complied with all Medicare payment rules before Medicare writes the check. Most claims are reviewed after the fact, but that has set up a pay-and-chase approach to program-integrity that CMS is trying to escape.

The prepayment RAC demonstration will take place in 11 states, four of which — Pennsylvania, Ohio, North Carolina and Missouri — were selected because they have lots of Medicare claims for short inpatient hospital stays. The other seven states — Florida, California, Michigan, Texas, New York, Louisiana and Illinois — have high rates of “fraud-and-abuse prone providers,” CMS says. RACs will focus prepayment reviews on certain kinds of claims that historically trigger improper payments.

Prepayment audits are a strain on providers because they suspend payments for services unless the claims are given a clean bill of health. “I call it prepayment denial,” Wachler says. “I have found prepayment review extraordinarily difficult from a cash flow perspective, and there is no procedural mechanism to get off it.” He understands the merits of reviewing claims before they’re paid, but worries contractors have too much discretion. “What accountability do the contractors have? There need to be mechanisms in place to protect providers,” he says. One of his provider-clients had a targeted medical review that lasted 2½ years, which meant claims were not paid without first being reviewed. All denials are appealed, but cash flow is already cramped, Wachler says.

**After Hospital Repays MAC Millions, RAC Audits Same Claims and Recoups Again**

For Trinity Health, sometimes it feels like nice guys finish last. After one of the Michigan-based integrated delivery system’s subsidiary hospitals voluntarily repaid millions of dollars to its Medicare administrative contractor (MAC) for medically unnecessary one-day stays, the recovery audit contractor (RAC) hit the very same claims. So far, the RAC has recouped $2 million, which means that Trinity has paid back a portion of the money twice, according to Trinity’s calculations. Its complaints have fallen on deaf ears, says Andrei Costantino, director of organizational integrity, despite CMS promises that different program-integrity contractors won’t mess with the same claims.

“We are being penalized for doing the right thing,” Costantino told AIS in March 2012. “We are now repaying it a second time.”

The RAC-MAC double trouble began with “a very large repayment” to the MAC, National Government Services (NGS). It stemmed from one Trinity hospital’s claims for one-day stays. The hospital identified the error through its own compliance reviews, and then hired a consultant to help determine the scope of the error, which was done through statistical sampling and
extrapolation, Costantino says. Then the RAC, CGI Federal, started auditing the very same claims that were the subject of the repayment, and denying them, which triggered recoupment. The RAC told Trinity it won’t remove any claims from the RAC review and denial process until NGS gives the word, despite receiving detailed information from Trinity supporting the voluntary repayments to the MAC, Costantino says. “We are almost positive this is not how CMS wants the programs to be run,” he says.

One cause for the quagmire is the trouble Trinity has had identifying someone at NGS to resolve the repayment issue with CGI, Costantino says. After four months, however, and with the helping hand of its external legal counsel, Trinity found a person at NGS “who is now diligently working on helping us with these issues.” As a result, Costantino is confident that in the end, Trinity will get the duplicate repayments back. But he finds it baffling that the RAC and MAC won’t end the audits of erroneous claims that have already been repaid; they’re wasting everyone’s time. The only explanation from the MAC is that it’s examining Trinity’s statistical sampling methodology.

Costantino says that challenges always arise when dealing with repayments that involve statistical sampling and extrapolation, including identifying the population, sampling frame, and extrapolation. “What experience tells us is that statistical sampling has always been a well-accepted means by the government of addressing overpayment issues. Since the Trinity subsidiary was dealing with an enormous population that covered several years, the only practical solution was using a government-approved statistical sampling methodology. Reviewing all claims in the population was not only impractical but time- and cost-prohibitive,” Costantino contends.

If, however, the MAC challenges Trinity’s extrapolation, that could change the repayment amount. But meanwhile, he says, it’s confusing why NGS would not reach out to the RAC to suspend its review until this process was completed. That’s cause for concern now that providers may face a 10-year look-back period under the 60-day overpayment return mandate, if CMS finalized its proposed regulation with that audit period intact.

“It’s depressing. We keep spending money and fighting RAC denials for the same claims we repaid,” Costantino says. “We could be using that money for quality of care instead of spending money to fight contractors,” he says.

To prevent RAC audits when you have already repaid MACs, hospitals may want to consider skipping extrapolation in favor of a claim-by-claim repayment, says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind. That way, RACs have no reason to get involved. But repayments that don’t rely on extrapolation are more expensive because they identify claims patient by patient and claim number by claim number, he says. Unfortunately for Trinity, Wade says, “the MAC may be using the RAC to verify the extrapolation process.”

**RACs Deny Admissions for Inpatient-Only Procedures; CMS Says There’s More to It**

Some admissions for procedures on the Medicare inpatient-only list are being rejected as medically unnecessary by recovery audit contractors (RACs). That may seem like an oxymoron because Medicare doesn’t pay for procedures on the list unless they are performed on an inpatient basis. But apparently hospitals may face claims denials — in some cases perhaps be-
cause RACs don’t know the procedures are on the inpatient-only list or hospitals don’t realize
they are not — and in some cases unfairly.

Whatever the reason, hospitals that appeal these cases may have to do more than invoke
the inpatient-only list; they may have to establish the medical necessity of the procedure
and/or the admission, and show that placing the patient in observation would have been
inappropriate.

Bay Regional Medical Center in Michigan, for example, recently won its appeal of a RAC
denial for admitting a Medicare patient for an inpatient-only procedure. But it was hard
won, said Compliance Officer Mike Jamrog in April 2012. The hospital went all the way to an
administrative law judge after the RAC denied the claim and its denial was upheld two more
times. Ultimately, the ALJ agreed with the necessity of the procedure and the patient’s admis-

sion based on medical records and the hospital’s phone testimony from the utilization review
specialist and a physician adviser, and noted the procedure’s presence on the inpatient-only
list. But the case sticks in Jamrog’s craw, notwithstanding the victory.

“It was so black-and-white we couldn’t understand why we had to take it to the third lev-
el,” he says. “You can’t tell us this procedure is on the inpatient-only list because it is so severe
and then turn around and say ‘you shouldn’t have done it at that site and now you won’t get
paid for it.’”

According to the ALJ decision, the RAC in January 2011 denied an inpatient claim for a

patient admitted to Bay Regional Medical Center for an elective surgery, popliteal to posterior
tibial bypass using saphenous vein graft, which involves using a vein to fix a defective artery.
The RAC declared that the patient could have been safely treated on the outpatient side. The
hospital appealed, and on redetermination, the MAC denied the appeal because the outpa-
tient setting was safe enough for this patient. At the next level, the QIC also denied the appeal,
saying “the patient was medically stable on presentation for an elective surgery and remained
stable without any post-procedure complications.”

With Jamrog as cheerleader, the UR specialist and physician adviser presented an appeal to
the ALJ that was both regulatory and clinical. The UR specialist pointed out that the surgical
procedure is on the inpatient-only list (CPT 35151, repair defect of artery). If the hospital had
billed for outpatient/observation instead, it would not have been paid by Medicare. In addi-
tion, the physician adviser “opined that the beneficiary required an inpatient admission post-
surgery because this was a very serious surgery,” the ALJ wrote. The vascular surgeon takes
a vein from the leg and grafts it to a defective artery; “a stent and balloon would not have
worked,” the physician told the ALJ. “The operative report asserts that the procedure included
a vertical incision from the knee to the ankle.”

When making their decisions, ALJs are not bound by any Medicare policy or CMS program
guidance except national coverage determinations. In other words, the ALJ’s hands are not
tied by the inpatient-only list, which contains the CPT/HCPCS codes that are reimbursed by
Medicare only when the services are provided on an inpatient basis. The list is Addenda E to
the inpatient prospective payment system regulation and is updated annually, which means
procedures are added and deleted on a regular basis, says Washington, D.C., attorney Al Shay,
with Morgan, Lewis & Bockius. However, ALJs may consider CMS rulings and manuals be-
cause they provide guidance in administering Medicare, the decision notes.
Admission Is a Complex Medical Judgment

In tackling the Bay Regional Medical Center case, the ALJ relied in part on Chapter One, Section 10 of the Medicare Benefit Policy Manual (Pub. 100-2), which addresses the reasons for hospital admission covered by Medicare. “Physicians should use a 24-hour period as a benchmark…and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment that can be made only after the physician has considered a number of factors,” including the severity of the patient’s signs and symptoms, the medical predictability of something bad happening to the patient, whether diagnostic studies can be done on an outpatient basis, and “the availability of diagnostic procedures at the time when and at the location where the patient presents.”

The ALJ also cited the Medicare Program Integrity Manual (Pub. 100-8), which states that “review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable and appropriate for the diagnosis and condition of the beneficiary at any time during the stay.”

After weighing the evidence, the ALJ first determined the hospital satisfied “the necessary criteria for the services provided.” The ALJ also concluded that the physician’s decision to admit the patient “was consistent with Medicare guidelines” and that observation was not the right site of service. The ALJ was persuaded in part by the fact that the beneficiary had major surgery to fix a blocked artery. “The beneficiary’s intensity of services showed why the inpatient level of care was appropriate and could not have been provided in an outpatient setting,” the decision states. If documentation supports the attending physician’s decision, the ALJ will defer to it. Also, the ALJ noted, the procedure is on the inpatient-only list. The ALJ then directed Medicare to pay the hospital’s claim.

Apparently, the message from this case and others is that a procedure’s presence on the inpatient-only list is not a bulletproof vest. RACs may still deny the claims, and even when hospitals win their appeals, it may require additional proof of medical necessity. “The ALJ used the medical record evidence to confirm the severity of the patient’s condition and need for the surgery, which was complicated. The fact that the procedure was on the inpatient-only list was further support that the admission was appropriate,” Shay says.

What’s troublesome is that the RAC denied it in the first place and was supported by the MAC and QIC, according to Jamrog, Shay and others. “No one does cardiovascular surgery of this type on an outpatient basis,” Shay says.

But sometimes things are more complicated than they seem.

Connie Leonard, director of the CMS Division of Recovery Audit Operations, told AIS in April 2012 that RACs don’t start audits with the idea they will deny procedures on the inpatient-only list. “In some of the cases we have reviewed, the provider has thought that the issue was on the inpatient-only list when it really wasn’t. There currently is not a crosswalk from the inpatient-only list to the applicable DRGs. This may cause difficulty for providers when they are billing. There are also issues where a provider billed for a procedure on the inpatient-only list but when the recovery auditor reviewed the claim, they determined that the medical record had documentation of another procedure being completed that was not on the inpatient-only list.”
CMS Wants to Hear From Providers

Leonard says that providers can appeal these denials. “We encourage providers to contact CMS if they feel this situation occurs. We also are reviewing how a crosswalk could be created for recovery auditor review to ensure consistency. At this time I am not sure if this will be possible.”

But there is frustration in some quarters with the HHS appeals process. For one thing, decisions don’t set any precedence, says Robert Jacobs, president of Health/ROI in Lake Success, N.Y. An ALJ can take a stand on a medical necessity issue or inpatient-only procedures, but it won’t help anyone but the hospital appealing the case, he says. And there is so much variation in ALJs’ perceptions of the laws and whether they defer to attending physicians, so outcomes are unpredictable. Although ALJs are perceived as a more deliberative, less biased appeals body than MACs and QICs, they have recently been taking “a more stringent view of one- and two-day inpatient stays,” says Ellen Scott, appeals management director for Health/ROI. “They are not as willing to overturn [RAC] decisions.”

Given what has transpired, Bay Regional Medical Center now immediately checks all RAC denials to see whether the procedures are on the inpatient-only list, Jamrog says. If they are, “it’s a high priority case” — all the way to the ALJ, he says. ♦