

IS YOUR FACILITY READY FOR MEDICARE AND MEDICAID AUDITS?

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QUOTE OF THE MONTH

“The man who believes he can do something is probably right, and so is the man who believes he can’t.”

If your facility has not yet received an **audit notice** from **Center of Medicare and Medicaid Services (CMS)**, you will most likely receive one soon. Every Medicare and Medicaid provider is now on the CMS's audit plan.

The Office of Inspector General is presently conducting a review of irregular Medicare Payments for inpatient services. The objective of these reviews is to evaluate controls used to detect potentially excessive Medicare payments made to healthcare providers for inpatient services. Based on a report from The Centers for Medicare & Medicaid

Services, nearly \$440 million has been collected since the program began in 2005. Approximately 96 percent of the improper payments identified by in 2007 were overpayments collected from health care providers; the remaining 4 percent were underpayments repaid to health care providers. There are several reasons for these audits based on Medicare reimbursement claims that was submitted by your facility. In general, the request for these audits is to identify:

1. Is the information on the claim(s) correct?
2. Do the charges billed for each procedure or service matches the amount on hospitals CDM?
3. In event of overpayments, what controls are in place to ensure that any overpayments resulting from incorrect claims are identified and refunded to Medicare program and beneficiary?
4. What corrective action plan is in place to prevent incorrect billing and to identify incorrect payments?

CMS PROPOSES 3% BUMP IN OUTPATIENT PAYMENT RATE

Medicare is proposing to increase payment rates for outpatient services by 3% to more than 4,000 hospitals and other facilities next year in an inflation rate update under the [Outpatient Prospective Payment System](#).

The CMS projects it will pay these providers \$28.7 billion in calendar year 2009, compared with projected payments of \$26.9 billion this year. In addition, the CMS projects it will pay \$3.9 billion to ambulatory surgery centers, an increase from

the \$3.5 billion these facilities were projected to receive in 2008.

The agency has recently begun tying outpatient payments to quality of care.

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For next year, the CMS is proposing to add four new measures on imaging efficiency to seven existing measures hospital outpatient departments must report data on in 2008, to get full payment for these services next year. Hospitals that don't meet these quality reporting requirements are penalized with a 2% payment reduction.

The agency is seeking comment on 18 additional quality measures that could be added to this list in the future, ranging from screening for fall risk to cancer care. Beth Feldpush, senior associate director for policy with the American Hospital Association, said

the AHA had concerns that none of the newly proposed measures have been endorsed by stakeholder quality organizations such as the National Quality Forum or Hospital Quality Alliance.

To promote efficiency in paying for imaging services, the CMS is proposing to make just one payment for multiple services of a particular type (such as multiple ultrasound procedures) conducted during a single hospital session. It is also seeking comment on options to modify outpatient payments for

preventable or "never events." The agency has already implemented a similar policy for preventable conditions acquired during an inpatient stay.

Congress froze ASC payments for six years with 2009 as the last year of the freeze, according to Kathy Bryant, president of the ASC Association, so ASCs are not getting a payment update. Increases in volume, changes in case mix and payment for procedures not previously covered, however, could account for the rise in payments from \$3.5 billion to \$3.9 billion.

Story posted: In Modern Health on

RAC PROGRAM

Implementation of the RAC program has been guided by reports from the Department of Health and Human Services Office of Inspector General and the Government Accountability Office. Based on the recommendations included in these reports and experience gained from their work conducting audits of Medicaid and the private sector health care claims, in 2007, the RACs in the three-state pilot returned a total of \$247 million to the Medicare Trust Funds after taking into

account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

The types of inadvertent errors leading to improper payments, found by the RACs, include the following examples:

A health care provider bills Medicare for conducting three colonoscopies on the same patient on the same day;

Payments are made for services that are coded incorrectly – for example Medicare is

billed for a certain procedure but the medical record shows that a different procedure was actually provided; A health care provider is paid twice because the provider submitted duplicate claims; or A claim is paid using an outdated fee schedule. In these examples, the RAC would issue a repayment request for the amount that was paid for the extra service or the incorrect coding. If the beneficiary paid wrong copayment amounts, the health care provider would need to reimburse the patient for those copayments.



The Washington Monument at dusk

MEDICARE...CONTINUED FROM PAGE 1

system for responding to audit requests, tracking audit activity, and appealing findings as appropriate. Hospitals need to assess and improve their clinical documentation processes both in preparation for the audit and as a result of any audit findings. Hospitals must bring finance, clinicians, and compliance professionals together to establish a consistent process that will ensure regulatory compliance and revenue integrity. In order to

establish a Proactive Audit Preparedness Plan, management must work on Uniting the Clinical and Financial Departments of the Hospital. So, be prepared by being proactive and establishing an audit program to prevent expediting corrective action plans after CMS has discovered your risk areas.

American Healthcare Audit Professionals (AHAP) is prepared to assist your staff and your facility in preparation for these Audits. Our experienced Nurse Auditors have

been assisting facilities with this very arduous task of audit preparations. AHAP will provide audit outcomes to our clients to identify areas of risk. AHAP Nurse Auditors will provide staff education as deemed necessary and assisting the appropriate department managers and nursing departments with maintaining and/or developing charge protocols and policies in all revenue producing departments.

- Julie Doumad RN, BSN, CMAS

Director of Audit Services

FILING AN APPEAL

To discourage the facilities from filing appeals just to delay recoupment - interest is charged. If for example the denial is for \$500 and you decide to appeal- the RAC cannot take back the money. But while you are in the ENTIRE

appeal process - which has 3 levels - interest will accrue on the \$500 as long as you continue to appeal. If you win, it goes away. If not, it is included in the recoupment.

When deciding to appeal, make sure the appeal is worth it. But

don't give up just because of the interest penalty. It is essential to track and trend all potential 'vulnerabilities' along with actual denials.



Independence Day

is observed in the United States on July 4. On that day in 1776, the Continental Congress adopted the Declaration of Independence. In France, a similar holiday, Bastille Day, occurs on July 14. Several other countries celebrate national independence in July. Canada celebrates July 1 as Canada Day. Independence Day is celebrated in Venezuela on July 5; in Argentina, July 9; in Belgium, July 21; and in Peru, July 28.

RAC...CONTINUED FROM PAGE 2

The RAC demonstration is a key tool CMS uses to assure payments to health care providers are accurate and proper and that the number of errors in Medicare claims continues to decline. Medicare calculates the error rate - the amount of incorrect claims that

are submitted by health care providers - as part of the Comprehensive Error Rate Testing (CERT) program.

Since CMS began the program, the error rate dropped from 14.2 percent in 1996 to 3.9 percent in 2007. This decline in improper

payments reflects CMS' efforts to target erroneous claims processing, inaccurate billing and errors by health care providers.

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MAKING A DIFFERENCE WHERE IT COUNTS...

MEDPAC RECOMMENDATIONS

Story posted: June 13, 2008 - 3:00 pm EDT Modern Healthcare

The Medicare Payment Advisory Commission in its June [report](#) to Congress made a series of recommendations to reform Medicare's payment system and make providers more accountable for the quality of care they provide.

The commission made specific recommendations in three areas: primary-care, care provided around a hospitalization, and skilled-nursing facility payments. To improve care coordination and efficiency, the panel recommended reducing payments to hospitals with relatively high readmission

rates for select conditions, and suggested that the CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions.

In addition, HHS should confidentially report to hospitals and physicians information about resource use around a hospitalization—such as inpatient stays—and readmission rates. After two years of confidential disclosure to providers, this information should be reported publicly.



JUST A FEW IMPORTANT JULY EVENTS:

American troops occupied San Juan Hill in the [Spanish-American War](#), July 1, 1898.

[President James Garfield](#) shot, July 2, 1881.

Continental Congress adopted the [Declaration of Independence](#), and [John Hancock](#) signed it, July 4, 1776.

[Calvin Coolidge](#), 30th President of the United States, born in Plymouth Notch, Vt., July 4, 1872.

Japanese and Chinese troops clashed, beginning the struggle that became World War II, July 7, 1937.

U.S. astronaut [Neil A. Armstrong](#) became the first person to walk on the moon, July 20, 1969.