

AUDITOR'S CORNER

It's a time for sharing and spreading happiness. Wishing all of you a very Happy Thanksgiving...



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RAC OPINION-STEERING

While the CMS touts the benefits of the Medicare Recovery Audit Contractor program, some call it 'bounty hunting' Gotcha!

That's the word that Gerald Worrick, president and chief executive officer of 25-bed Door County Memorial Hospital, in Sturgeon Bay, Wis., uses to describe the new federal Medicare Recovery Audit Contractor program that was officially unveiled last week.

The RAC program was created by the Medicare Modernization Act of 2003 to identify and correct improper Medicare payments paid to healthcare providers in fee-for-service Medicare. Under the program, third-party auditors get to keep a percentage of improper payments they identify and collect from providers. The CMS, which pilot-tested the RAC program in several states, believes it will cut down on fraud and save the government money.

Hospital industry executives don't see it that way. The program essentially assumes that hospitals are trying to cheat the system, despite the fact that most providers try to make decisions that are in the best interests of the patient, Worrick said.

"I find it fascinating that after the federal government designs the most complicated billing system on earth, they come back and audit us with another new complicated system" that is going to test hospitals on how well-versed they are on the thousands of pages of regulations that govern the billing process, Worrick said. "It's a system of gotchas," he said in summary of what lays ahead for the hospital industry. HHS is required by law to implement the RAC program in

all 50 states by Jan. 1. For now, each of the four companies named last week as RACs will be auditing providers in 19

states under the first phase-in of the program that began last week. Each RAC will be responsible for identifying overpayment and underpayments in approximately one-quarter of the country, according to the agency. When the CMS announced the four contractors last week, PRG-Schultz International was excluded as one of the four contractors, a decision that was welcomed by some providers .

Despite some changes made to the program between the pilot and final versions of the program, providers and consultants still are finding fault with the RAC program.

They argue that changes made between the pilot program and the version unveiled last week didn't go far enough to solve problems with the program.

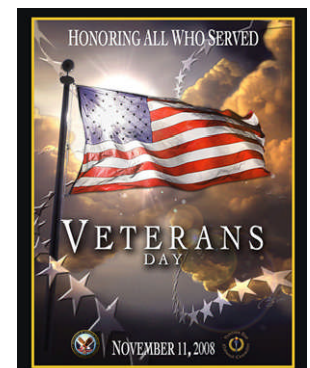
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QUOTE OF THE MONTH

"The difference between a successful person and others is not a lack of strength, not a lack of knowledge, but rather in a lack of will."

Vincent T. Lombardi

All citizens of the United States of America owe their very freedom to those proud and brave veterans who have served. May God bless the veterans of all American wars, both past and present, because they have blessed us with freedom by their service.



THE TIME FOR ICD-10 ADOPTION IS NOW

It has been 15 years since the National Committee on Vital and Health Statistics recommended that ICD-9 should be replaced, and eight years since that body recommended that ICD-10 should be adopted. On Aug. 22, the [proposed rule](#) for "Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS" was finally issued. The proposal calls for replacing the ICD-9-CM for all morbidity and mortality classification, and replacing the ICD-9 procedure classification with ICD-10-PCS in acute care. The proposed effective date for the switchover is Oct. 1, 2011.

Meanwhile, the comment period ends Oct. 21 of this year. Developed in the 1970s, the ICD-9-CM classification system does not effectively represent 21st century medical concepts and technology and therefore cannot support the many ways these data are used today. Clearly, ICD-9 lacks sufficient specificity and detail, and no longer reflects current knowledge of disease processes, contemporary medical terminology or diagnostic and therapeutic procedures. And while the diagnosis and procedure classifications have been updated nearly every year for the past 30 years, ICD-9 has, literally, run out of codes to accommodate advances in medicine and medical technology. There is no question that the changeover from ICD-9 to ICD-10 CM and ICD-10 PCS for hospitals is a significant undertaking, but there are three key reasons why our industry needs to make this happen soon.

□ The value of data: First, ICD-10 will improve the value of the huge investments being made to facilitate the collection, reporting and exchange of data in the U.S. The

administrative burden is growing while the information value is deteriorating because of obsolete code sets. Many quality measures, such as those from HealthGrades and the Agency for Healthcare Research and Quality, rely on ICD-9-CM codes. ICD-10-CM will provide far greater information value by better describing conditions, comorbidity and complications. ICD-10-PCS will permit comparative effectiveness research on new medical technologies. The finer detail and cleaner logic of the codes will better support clinical research. For instance, knowing whether and under what circumstances laparoscopic surgery improves healthcare outcomes as compared with open surgery would affect thousands of lives and could save billions of dollars. There are many other similar examples of very important improvements that will add real value and aid decision making. Public health and epidemiology: More than 100 countries use some form of ICD-10 for clinical morbidity reporting. The World Health Organization released ICD-10 in 1990 while other countries began implementing it in 1994; most were fully implemented by 2000. As the international diagnosis classification standard, ICD is used to catalog diseases and other health problems recorded on vital and medical records, and are the basis for compiling national mortality and morbidity statistics and analyzing the incidence and prevalence of diseases. As a

member of the WHO, the U.S. is required to notify the organization of all events that constitute a public health emergency of international concern and to respond to requests for verification of information regarding such events.

ICD-10-CM is also simply more effectively designed to capture public health diseases than ICD-9-CM. Research shows that its greater specificity more fully captures nationally reportable public health diseases, diseases related to the top 10 causes of mortality and conditions potentially related to terrorism.

Innovation in data analytics: ICD-10 is an integral part of the health information improvement agenda for the U.S. Too often classification systems are seen as tangential to electronic health records, clinical decision support and health information exchange when, in fact, they are very central. The value of the technologies depends on having reliable and useful data. ICD-10 data are more easily retrieved in electronic format than ICD-9-CM data. The full benefits of a reference terminology such as SNOMED CT will not be realized if that system is mapped to an obsolete classification system such as ICD-9-CM. Application developers will be encouraged to invest in computer-assisted coding solutions because the logical structure of ICD-10-CM and ICD-10-PCS simplifies the development of map rules and algorithms used in these applications. This will save money, improve work flow and allow highly skilled coders to move into data quality roles. In short, ICD-10 will be a catalyst for advances in health data analytics.

I have not once mentioned billing or reimbursement. Coded data are the basis for DRG-based payment systems, but disease and procedure classification (read coding) is not merely a billing function. This is a very important use that adds to the complexity of the transition to ICD-10. However, payment systems needn't be changed until sometime after the transition when there is sufficient data to develop improvements.

We have reached the witching hour on this decision. The American Health Information Management Association goes on record [supporting](#) the transition to ICD-10. Well aware of the cost, burden and nuisance of this change, the U.S. has no choice. We must end 15 years of debate and begin serious national planning for a successful transition.

Updating our information infrastructure is fundamental to healthcare reform, patient safety and quality improvement. ICD-10 is an important building block in that infrastructure.

Linda Kloss, Chief executive officer AHIMA, (Chicago)

Posted: October 13, 2008 - 5:59 am EDT
Modern Healthcare

DEFINITION OF SUCCESS...

There is no one, all-encompassing definition of success because success is a relative concept. Success, in the action sense, is achieving something you have set

out to do and wanted to do. But what about the connection between success and happiness? What if what you've accomplished doesn't

bring you true happiness and satisfaction? Are you still successful simply because you completed something?



RAC OPINION (1)...CONTINUED FROM PAGE 1

They also say that question marks still hang in the air over unresolved appeals to audits that took place during the program's three-year demonstration project, and that over the long term, hospitals and other providers will lose, not gain from the program.

Bottom line, "the long-term impact is CMS has allowed bounty hunting in healthcare," said Bruce Hallowell, a partner and practice director of the finance and revenue cycle for Computer Sciences Corp., or CSC, a consulting, systems and outsourcing company in Falls Church, Va.

A money-saver?

But the CMS strongly backed the RAC program as a money-saver. Under the demonstration, "the cost to run the program was significantly less than the amount it recovered for Medicare—20 cents for every dollar collected," CMS acting Administrator Kerry Weems said at a forum sponsored last week by the Health Care Compliance Association and the American Health Lawyers Association.

Overall, the RACs identified more than \$1 billion in improper payments during the demonstrations, Weems said.

But Hallowell disagreed with the notion that it's a money-saver. Hospitals are going to have to increase their costs to protect themselves from RAC, he said. "So it is my opinion that in the short term (the program) will give money to CMS, but in the long-term it will cost the program more than they are saving," he said.

Monica Phillips, a business analyst in the managed-care department at not-for-

profit, two-hospital Palomar Pomerado Health in San Diego, wonders about the logistics of launching the program nationwide with only four contractors, when there were so many problems with piloting the RAC program in just a few states. Palomar, which also includes two skilled-nursing facilities, expects it will have to hire at least two more full-time employees to address the demands of an audit.

"We don't know how they're going to be handling appeals and the retractions, and how we are going to be impacted," Phillips said.

Contractors that participated in the demonstration project were widely criticized by lawmakers and providers alike for collecting funds before settling appeals, or not following the same rules that other auditors have followed. The program drew other complaints, including the fact that contractors could go back in time farther than was necessary to look up claims.

Rep. Lois Capps (D-Calif.), a lawmaker who has been tracking the impact of the RAC program in her state, has concerns about the appeals process issues from the demonstration program. "We all want to make sure tax dollars are spent wisely, but the demonstration program inappropriately rejected claims far too often, unfairly hurting providers and their patients," Capps wrote in an e-mail.

Capps has requested that the government Accountability Office report on the program's effects on providers and patient care. "I want to make sure we don't see the same problems in the permanent program, so I'll be making sure Congress keeps a close eye over this program going forward," she wrote.

Weems claims the majority of providers gave the RAC demonstration program good marks. "We know this because we had Gallup conduct a telephone survey between May and July 2007. Seventy-four percent of respondents said our efforts to recoup overpayments were fair and reasonable. Seventy-one percent thought that RACs applied Medicare policies correctly," he said.

Don May, vice president for policy at the American Hospital Association, said hospitals are interested in "starting off on the right foot" with the RAC program, and the AHA plans on working with the CMS and new contractors through training programs and other modes of communication "to make sure this is implemented in a methodical and fair way." The CMS this month plans to set up training sessions with state medical and hospital associations to educate them on how to communicate with RACs, he said.

Changes made

May added that he believes the CMS learned many lessons from the demonstration and, as a result, made some important changes to the permanent program. While supportive of those changes, however, "we want to make sure we move thoughtfully and slowly to get the real benefit of those changes," he said.

Among the new rules contractors must adhere to is they no longer get to keep their contingency fees if they lose at any level of appeal, and they have to have a medical director on staff to help make decisions on claims.

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MAKING A DIFFERENCE WHERE IT COUNTS...

RAC OPINION (2)...CONTINUED FROM PAGE 3

In addition, RACs have to make public their contingency fees as well as what areas they're targeting.

"If an audit results in denial of a claim, the medical director must be available to discuss the denial if requested to do so. If the denial is overturned at any level of appeal, the RAC must pay back the contingency fee," Weems said at the fraud forum last week.

May said that RACs have to get approval from the CMS on what areas they want to target. For example, a contractor may say: "We think we can find errors on one-day stays. This is the kind of review we want to do," and then CMS will approve, deny or modify," he said.

Another piece of good news is hospitals that self-disclose or conduct audits on themselves are exempt from RAC audits, CSC's Hollowell said.

But despite the concessions the CMS made to accommodate hospitals, he believes the

industry is still going to face major challenges to comply with RAC audits. Even with these boundaries in place, the volume of paper and electronic documents involved in a RAC audit will be overwhelming to a hospital that has limited resources, Hollowell said, summarizing the conclusions from a white paper he co-authored with other CSC colleagues.

"For every tagged claim the provider decides to investigate, there are clinical notes, completed forms, bills, lab results and other documents to review and reconcile. Locating all of the required documentation and investigating what is wrong with the claim is challenging and a significant resource drain" for hospitals, according to Hollowell. Another major challenge in responding to a RAC audit is the limited amount of time that providers are given to respond, Hollowell said.

Hospitals like Door County, a small critical-access Catholic hospital part of the Ministry Health Care system, is at a

particular disadvantage in complying with the RAC program, considering that it doesn't have enough people in its various departments to collect all of the information an auditor may ask for, Worrick said.

The hospital nevertheless is taking actions to prep for a RAC audit by appointing a task force led by its chief financial officer. The goal of the task force is to put some processes into place so the hospital can readily provide answers to a RAC auditor without having to hire additional staff, he said.

At Palomar Pomerado Health, the issue boils down to the basics of what hospitals are designed to do. "We just want to take care of patients and get paid for those services," Phillips said. "It's hard to keep our doors open when we're constantly being challenged."

By: Jennifer Lubell
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