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AMERICAN HEALTHCARE AUDIT PROFESSIONALS

AHAP Inc.

AUDITOR'S CORNER

ENSURING MEDICAL NECESSITY: LESSONS FROM THE TOP

There are many steps that inpatient hospital providers can take to avoid denial of their claims when submitting Medicare fee-for- service claims.

The Centers for Medicare & Medicaid Services (CMS) discussed numerous findings uncovered by Recovery Audit Contractors during a March 9, 2011 podcast. To prevent future improper payment issues, CMS encouraged providers to understand the "lessons learned" listed below, take necessary steps to meet Medicare documentation requirements, and implement corrective actions.

Types of Denials

Contractors in the Recovery Audit Program (RAP) identified the following:

- Medical necessity denials for multiple codes;
- Ambulatory surgical center coding errors paid at the inpatient rate rather than the outpatient rate; and
- Other outpatient charges that were not billed because the medical services provided were not medically necessary in the inpatient hospital setting.

According to CMS, these categories of medical necessity denials impact multiple codes but no coding trends were identified. Medicare contractors denied these claims because the medical documentation submitted did not:

- Support the diagnosis;
- Justify the treatment or procedures;
- Document the course of care;
- Identify treatment or diagnostic test results; and
- Promote continuity of care among healthcare providers.

Continued on pg. 3— Ensuring Medical Necessity..

QUOTE OF THE MONTH

"The bravest are surely those who have the clearest vision of what is before them, glory and danger alike, and yet notwithstanding, go out to meet it."

The costs associated with medical care and health insurance keep increasing at an alarming rate. Studies show 9 out of 10 medical bills contain errors. Regardless of how errors occur, AHAP experienced staff of Nurse Auditors and Certified Coders offers a comprehensive approach to identify and provide prompt and professional service to insure that service & charges rendered to the patient are accurate and correct.

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PHYSICIAN INCORRECTLY BILLED PLACE OF SERVICE 90 TIMES

The Centers for Medicare & Medicaid Services (CMS) released a special-edition MLN Matters article titled "The Importance of Correctly Coding the Place of Service by Physicians and Their Billing Agents." This article, released by CMS on March 9, 2011, was a follow-up to a July 2010 report from the acting deputy inspector general for audit services to CMS Administrator Don Berwick.

That report detailed the results of a review of place-of-service coding for physician Part B services billed during the 2007 calendar year. The audit covered 484,218 non facility-coded physician E/M services that were matched to hospital outpatient or ASC for the same patient on the same day, being responsible for more than $42 million in charges.

In a review of 100 sample services, physicians incorrectly coded the place of service 90 times. In this small sample, the resulting overpayments amounted to $4,710. Extrapolated to the larger population, the overpayment for "place-of-service" payments was estimated at $13.8 million. The recommendation of the report was to recover the $4,170 identified in the audit immediately and then reopen the unaudited 484,118 non-sampled services to recover the estimated $13.8 million.

Background

In the RVU system utilized in physician payment, the three critical components of relative value calculation are physician work, malpractice expense and practice expense. The practice expense component, contributing to physician payment, varies based on a distinction between "facility" and "non-facility" sites.

Basically, facility settings are hospital and ASC sites where the physician incurs substantially less practice expenses than in the office or at other non-facility locations, where additional practice expenses are incurred. To account for the increased overhead expense physicians incur to provide services in facilities where they pay practice expenses, Medicare reimburses at a higher rate for "non-facility" services. By misidentifying the place of service as non-facility, physicians in essence are double-charging Medicare for practice expenses for which the facility already is being compensated.

The 90 percent error rate cited in the aforementioned audit exposed physicians to extensive payment recovery, which we anticipate to proceed rapidly. Recall that the $13.8 million recovery is for incorrect place-of-service billing for only the 2007 calendar year.

Continued on pg. 4— Physician Incorrectly Billed..

INSIDE STORY HEADLINE

Remembrance for all
Who answered the call
By placing their lives in harm's way.

This day should not pass with regret,
We owe an unpayable debt
To all the bravehearted,
Those valiant departed,
Whose sacrifice we'll not forget.

For freedom their lives served as shields,
Advancing in war's ravaged wealds
'Gainst tyranny's fist
They made the resist,
Triumphant on battle-torn fields.

In skies, upon seas or on land,
Whatever the point of command,
They stormed ev'ry hell
Where heroes' blood fell
'Til God gave them rest by his hand.

In shadows of Old Glory's wave
We cherish the mem'ries we save
Of those who stand tall
In Patriots' Hall –
By Freedom salute we The Brave!

By Travis Brasell

ENSURING MEDICAL NECESSITY...CONTINUED FROM PAGE 1

Pointers for Proper Documentation

To justify Medicare claims payment, CMS gives hospital providers the following guidance:

First, make sure that the medical record contains sufficient documentation to demonstrate that the patient's signs and symptoms were severe enough to require inpatient hospital medical care.

Also, make sure physicians are documenting any pre-existing medical problems or extenuating circumstances that make the beneficiary's admission medically necessary. Factors resulting in a simple inconvenience to the beneficiary are not enough to justify an inpatient admission. The beneficiary requires inpatient care only if his or her medical condition, safety, or health would be significantly and directly threatened in a less intensive setting.

When making the decision to admit, physicians should remember to consider four basic factors. In addition to the severity of the signs and symptoms exhibited (already mentioned above), they also should consider the medical predictability of an adverse happening to the patient, the need for diagnostic studies, and the availability of diagnostic procedures at the time and location where the patient presents.

In addition to the above, note the following:

Non-legible documentation affects the RAC's ability to support the medical necessity and appropriate setting of the billed services. CMS encourages providers to complete all fields on documentation tools, such as assessments, flow sheets, and checklists. If a field is not applicable, CMS recommends use of "N/A" or "not applicable" to show you reviewed and answered each question. Fields that you leave blank can lead the reviewer to make an inaccurate claim determination.

Comply with your inpatient hospital policies and the American Hospital Association's *Coding Clinic* guidance (http://www.ahacentraloffice.com/ahacentraloffice/index.shtml).

Ensure that medical record entries, including (but not limited to) the following are consistent. assessments; treatment plans; physician orders; nursing notes; Medication and treatment records; admission and discharge data; pharmacy records; and other documentation. When one entry contradicts previous documentation, include documentation that explains the contradiction.

Provide adequate documentation of significant changes in the patient's condition or care that could impact the review determination.

Carol Spencer, RHIA, CCS, CHDA, is a senior healthcare consultant with Medical Learning, Inc. in St. Paul, Minn. RAC monitor April 20, 2011

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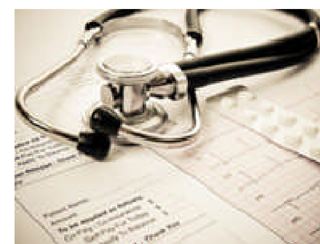
"When making the decision to admit, physicians should remember to consider four basic factors. In addition to the severity of the signs and symptoms exhibited"

CMS REPORTS $365.8 MILLION IN IMPROPER PAYMENTS

The Recovery Audit Contractor (RAC) program has identified $365.8 million in improper payments in the period from October of 2009 through the end of March 2011. From this number, $313.2 million were overpayments and $52.6 million were underpayments that were returned to providers, according to an update on the CMS website under "Recent Updates. http://www.cms.gov/RAC/Downloads/FFSNewsletter.pdf

Written by: Chuck Buck RAC monitor April 26, 2011



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- *RAC & OIG Audits*
- *Certified Coding*
- *Case Management & Utilization Review*
- *Appeals & Denials Management Services*
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MAKING A DIFFERENCE WHERE IT COUNTS...

PHYSICIAN INCORRECTLY BILLED...CONTINUED FROM PAGE 3

In addition to reopening the un-reviewed 2007 claims, we can anticipate reviews of claims from other years. Furthermore, the Office of Inspector General for the U.S. Department of Health and Human Services is working to improve current program safeguards to avoid future overpayment of such claims.

It is critical that physicians and their professional billing staff correctly identify place of service to code correctly and avoid recoverable overpayments.

Example of Incorrect Coding [from the audit report]

A carrier paid a physician $374 for performing a spinal pain injection procedure coded as having been performed in his office. Our analysis showed that the physician actually performed this procedure in a hospital outpatient department and that a fiscal intermediary had reimbursed the hospital for the overhead portion of the service. If the claim had been coded correctly, the physician would have received a payment of $96, which would not have included overhead costs.

As a result of the incorrect coding, the physician was overpaid $278.

Written by Paul Weygandt, MD, JD, MPH, MBA, CPE

Paul Weygandt is a Certified Physician Executive (CPE) with more than 20 combined years of experience in medical management, legal counsel and orthopedic surgery.