



# Best Practices to Avoid Medicare Denials

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# Agenda

- **Overview of current audit environment and contractors**
- **Concurrent and appeal best practices**
- **Common documentation errors and recommendations**

# Today's Audit Environment

- If you are treating patients and submitting claims, you will be audited
- It is about how the contractors interpret the regulations:
  - The regulations haven't changed
  - The procedures haven't changed
- Providers must appeal or the contractors' interpretations become the new standard
  - Determinations based solely on screening criteria
  - Timing as sole determining factor (e.g., there is no 24-hour rule)
- The solution is NOT to make all prepayment reviewed cases 'observation'
- Appeal cases that are inappropriately denied

# Governmental Audit and Fraud Fighting Entities and Initiatives

<b>Who</b>	<b>What</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>DOJ</b>	<b>Department of Justice</b>
<b>MCR RAs</b>	<b>Medicare Recovery Auditors</b>
<b>MACs</b>	<b>Medicare Administrative Contractors</b>
<b>HEAT</b>	<b>Health Care Fraud Prevention and Enforcement Action Team</b>
<b>CERT</b>	<b>Comprehensive Error Rate Testing</b>
<b>MIP</b>	<b>Medicaid Integrity Plan</b>
<b>MIG</b>	<b>Medicaid Integrity Group</b>
<b>MICs</b>	<b>Medicaid Integrity Contractors</b>
<b>MIG</b>	<b>Medicaid Inspector General</b>
<b>MCD RAC</b>	<b>Medicaid Recovery Audit Contractors</b>
<b>PERM</b>	<b>Payment Error Rate Measurement</b>
<b>PSCs</b>	<b>Program Safeguard Contractors</b>
<b>ZPICs</b>	<b>Zone Program Integrity Contractors</b>



# Best Practices To Prevent Denials



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# Review Cases Concurrently

Recognize that success is attained by using consistent, daily tactics:

1. Case Management applies **current, strict** admission criteria to 100% of medical cases placed in a hospital bed, plus documents this review in an auditable format
2. ALL cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care
3. The Physician Advisor:
  - reviews the case
  - speaks with admitting physician, when needed
  - makes a recommendation based upon UR Standards
  - documents the decision in an auditable format on the chart (or in UR documentation)
4. Attending physician changes the order, as appropriate
5. Should run 7 days a week/365 days a year

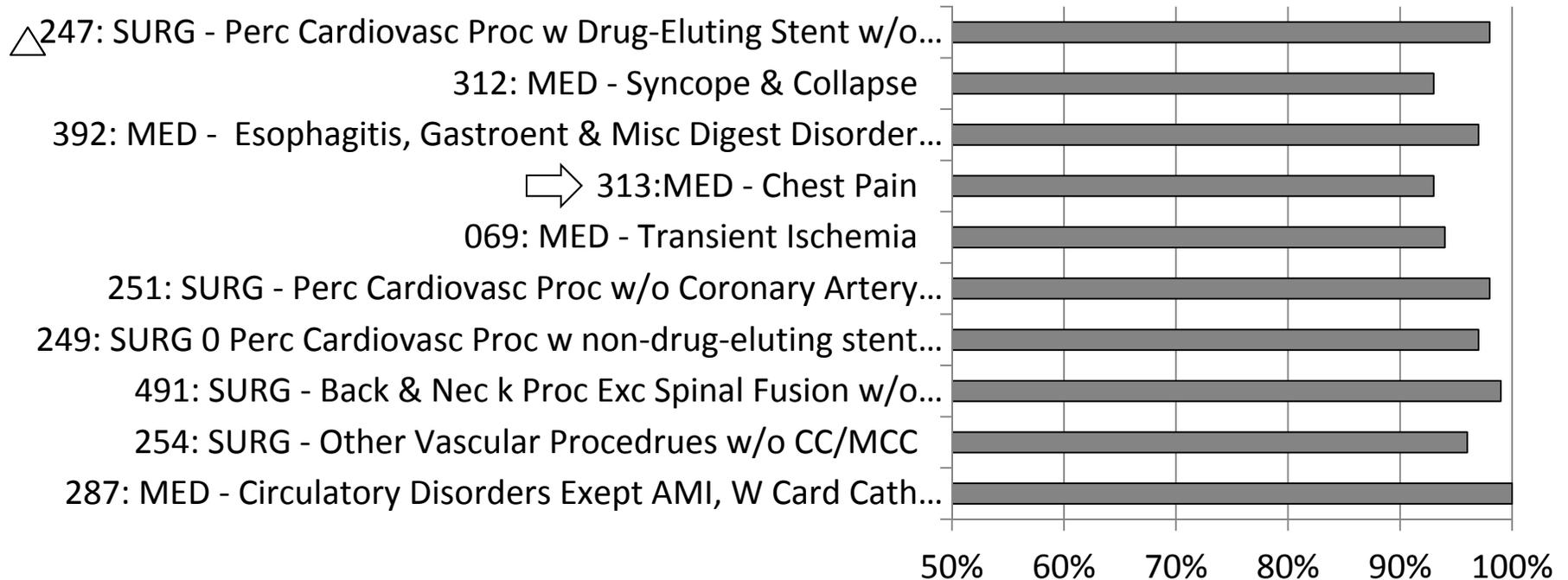
# UR Staff Screening Criteria Review: 'Keys to Success'

- Consider use of screening criteria that are recognized by your intermediary
- Apply screening criteria to 100% of FFS Medicare cases
- Ensure UR staff use screening criteria appropriately
- Inter-rater reliability testing to ensure appropriate use of criteria and valid decisions
  - Standardized case
  - Audit by case type
- Regular recurring education in the use of screening criteria
  - Especially in the case of UR staff turnover
- Ensure all cases that require secondary physician review are referred to a Physician Advisor for secondary physician review
  - Timeliness is key

# Physician Review: 'Keys to Success'

- Team
  - Almost impossible for one person to handle the volume
  - Requires different skill sets and knowledge bases
- Content
  - You cannot depend on the PA to “use their medical judgment” or opinion.
  - Must provide ‘library’ of evidence-based outcomes research across major diagnostic areas for decision making to be consistent and defensible
  - Without clinical references, cases will be hard to defend. Remember, the contractor also has a physician on staff.
- Training
  - Physician must be trained in medical management, CMS rules and regulations, and the evidence-based medicine mentioned above
- Quality Assurance
  - Best practice is a real time Q/A process to ensure highest quality of reviews

# 'Top 10' DRG Overturn Rates



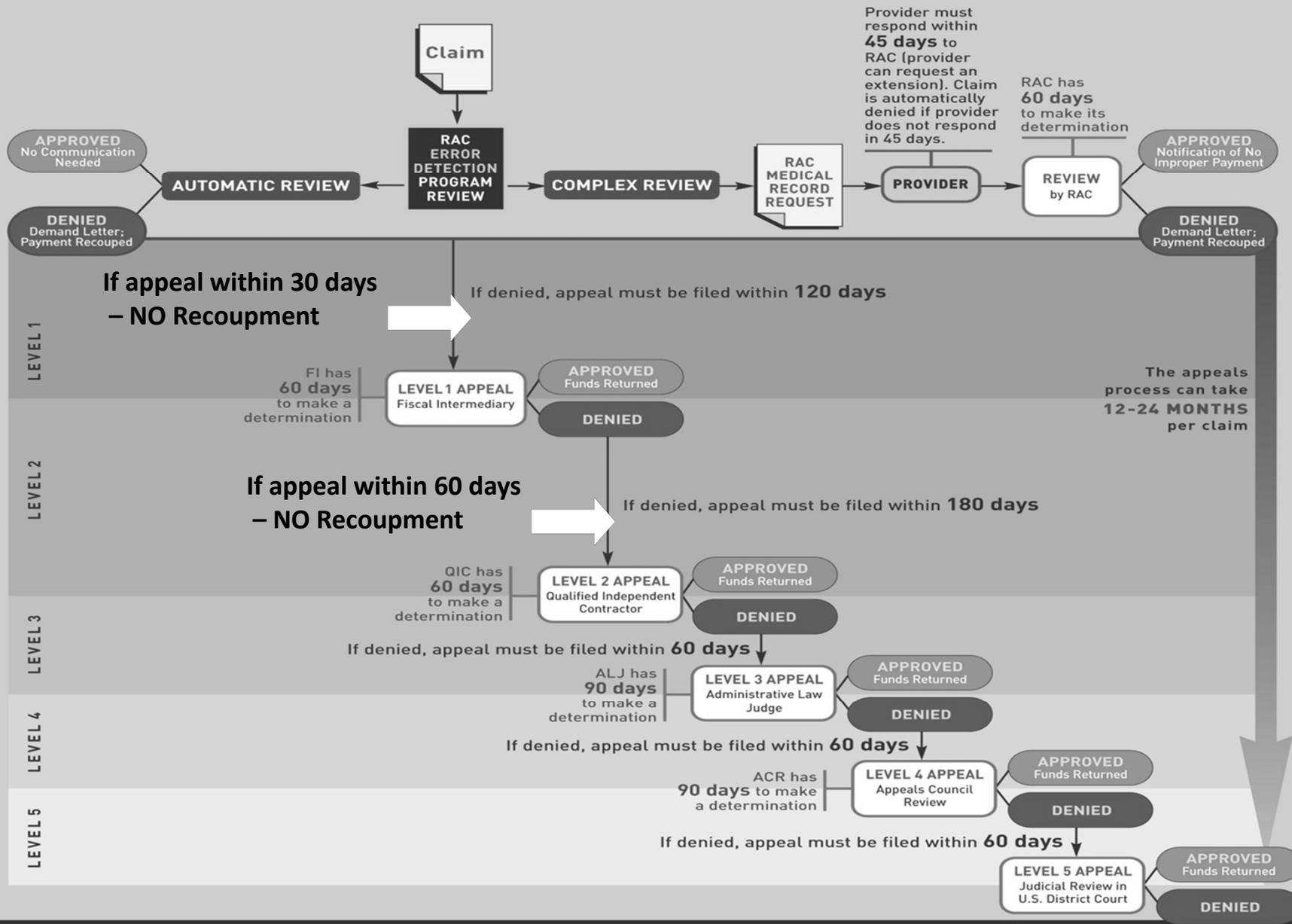
△ DRG 247 is the highest frequency DRG by volume with a permanent program overturn rate of 98%

⇒ DRG 313 has the lowest overturn rate of the Top 10, by volume, with a 93% win rate

## Three-Tiered Tactical Approach to RAC Appeals

- All reviewed cases and appeals should be designed and written to prepare for the ALJ level of appeal
- Your argument must address three key components to have a high likelihood of success:
  - **Clinical:** Strong medical necessity argument using evidence-based literature
  - **Compliance:** Must demonstrate a compliant and consistent process for certifying that medical necessity was followed
  - **Legal:** Want to demonstrate, when applicable, that the auditor has not opined consistent with the SSA and other regulations

# RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS



## ALJ Level of Appeal

- **Most overturns are achieved at ALJ**
- Key Observations
  - ALJ hearings are as varied as the ALJs themselves
- ***AXIOM: when you have seen one ALJ hearing, you have seen one ALJ hearing***
  - Different ALJs have different styles, and, as a result, often place different demands on the appellant
  - Preparation and experience are of paramount importance
- ***NEW DATA: 80% of contractors now have a physician or attorney attend the hearing***

# Establishing “Medical Necessity”

- Documentation is the difference
  - Explicitly detail why the care provided was medically necessary in the inpatient setting
- The critical factor:
  - The judgment of the admitting physician with reference to the guidance of the Medicare Benefit Policy Manual and other CMS Manuals
- Citation to relevant medical literature and other materials
  - Utilization management criteria, local and national standards of medical care, published clinical guidelines, and local and national coverage determinations may be considered

# Common Documentation Problems

- **Using a symptom rather than a diagnosis for the impression or assessment**
  - N/D/V vs. bowel obstruction
  - SOB, chest pain, headache, back pain
  - Listing the diagnosis as an intractable symptom (vertigo, abdominal pain, vomiting) without noting the potential diagnosis
- Using a lab value or treatment plan with no diagnosis
- Documentation for medical necessity is different than documentation for billing level or coding

# Common Documentation Reasons for UM Staff to Call Attending Physicians

- Limited or no physician documented info (consult, ED note or H & P) several hours after “admission”
  - Only information available is a list of symptoms/labwork/Interqual® evaluation
- No plan of care or clear impression in the H & P
  - Common with mid-level providers
- OP note/H & P for procedures that doesn’t address or include any risk from past medical history
  - Frequently occurs from using office notes as history and physical
- Lack of discharge summary for a readmission review and no mention of stability on discharge/return to baseline in the discharge note
- Continued stay review that doesn’t include the current progress note or orders to indicate why the patient requires continued acute care following stabilization
- To ensure the physician order matches the CM determination/billing status prior to discharge for billing concordance

# Common Vulnerability: Electronic Health Record

- All data is recorded but in different areas of the chart
- Find ways to ‘connect the dots’ for auditors
  - Demonstrate a consistently followed Utilization Review process in record
  - Find a way to include CM notes in record
  - Ensure physicians are demonstrating thought processes and detailed assessments of risk factors in their documentation somewhere in record
    - Physician impression/assessment dialogue box can be helpful
- Watch for COPY/CUT/PASTE

# Best Practice Summary

- Demonstrate a consistent Utilization Review process for every patient
- Educate medical staff on documentation practices to avoid future technical issues
- Hospitals need to be prepared to defend their decisions and advocate for their rights

# Remember...

- If you are treating patients and submitting claims, you will be audited
- Not all auditors are created equal
- Significant variation in interpretation of regulations by contractors
- Providers must appeal or the contractors' interpretations become the new standard

# Questions?

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FAEGRE BAKER  
DANIELS

# Private Contractor Actions: RACs, Z-PICs, etc.

Thomas Beimers

# Agenda

- **Today's Audit Environment**
  - Government Fraud Fighting Initiatives
  - Scope and Purpose of Contractors
- **Overview of Medicare Auditors**
- **Preparing for and Responding to Record Requests**
  - Clinical Considerations
  - Defenses
- **Best Processes for Success**
- **Lessons Learned**

# By The Numbers

- Scope of Problem
- Recoveries

# Issues with Government Audit Contractors

- OIG Reports
- GAO Reports
- Provider Criticisms
- CMS Response (Myths Document)

# Fiscal Intermediary/Carrier/MAC

- Fiscal Intermediary (e.g., Noridian) processes Part A claims
- Carrier (e.g., Wisconsin Physician Services) processes Part B claims
- FIs and Carriers replaced by Medicare Administrative Contractors (MACs)
- Round 2 Procurement process is ongoing
- Purpose: To process Part A and Part B claims correctly

# Fiscal Intermediary/Carrier/MAC

- Types of Reviews:
  - Automated Prepayment Reviews
  - Routine Prepayment Reviews
  - Complex Review
    - Requires medical record review
    - Focused on a specific provider
      - There's a reason they're looking at you – you're an outlier!
    - Focused on a specific service
      - Service-specific reviews are posted online
  - 30 days allowed to submit records in response to an Additional Documentation Request (ADR)

# Fiscal Intermediary/Carrier/MAC

- Preparing for Prepayment Reviews
  - Compliance should be immediately involved
  - Track status of all prepayment reviews (“probes”)
  - Understand why you’re an outlier
  - Review current processes and documentation practices
  - Consider putting a hold on claims
  - Review records before they go out the door
- Claims Subject to Review
  - Any claim submitted in past year
  - Any claims submitted in past four years for “good cause”

# Fiscal Intermediary/Carrier/MAC

- Current law places limits on prepayment reviews that can be conducted by Medicare Administrative Contractors (MACs)
  - Random prepayment reviews can only be conducted to develop contractor-wide or program-wide claims payment error rates
  - Non-random prepayment reviews can only be conducted on a provider or supplier following
    - identification of an improper billing practice, or
    - a likelihood of sustained or high level of payment error (i.e., the same standard that permits the use of extrapolation)
- 2010 law repealed limitation on the use of prepayment medical reviews by MACs



Alaska, Idaho,  
Minnesota, Oregon, Washington

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## INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS)

DRG 551-552

- Local Coverage Determinations (LCDs) →
- National Coverage Determinations (NCD) →
- Service Specific Reviews →
- Medical Review →
- Coding Assistance →
- Resources and Articles →
- Special Forms →
- CMD / Open Door Coverage Meetings →
- Skilled Nursing Facility (SNF) Demands
- Inpatient Prospective Payment System (IPPS)

Help with File Formats and Plug-ins

# Recovery Audit Contractor (RAC)

- **Purpose:** To identify and correct improper payments
- **Identity:** Contractors and sub-contractors
- **Scope of Review:**
  - Part A and Part B fee-for-service claims paid since October 1, 2007
  - Cannot review claims paid more than three years ago
  - Healthcare Reform expands RACs to Part B, Part C, Part D, and Medicaid
  - Issues pursued must be reviewed by an Issue Validation Contractor

# Responding to the Record Request

- Limit on the requested number of records
  - 1% of all claims billed in previous calendar year divided into 8 periods per 45 days
  - Campus includes all entities with same Tax ID that share the first three numbers of a zip code
  - Limits are based on a provider's claims volume
  - Request not to exceed 400 records per 45 days
  - Limit can be increased with a waiver from CMS

# RAC Issues

- Types of Reviews
  - Automated
  - Complex
- New Issue Review Process
  - Requires CMS to review and approve issues the RAC wants to audit
  - Issues approved by region
  - Approved issues posted on contractor websites

# RAC Approved Issue Websites

- Region A – Diversified Collection Services
  - <http://www.dcsrac.com/issues.html>
- Region B – CGI
  - <http://racb.cgi.com/Issues.aspx?st=1>
- Region C – Connolly Consulting
  - [http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)
- Region D – HealthDataInsights
  - <https://racinfo.healthdatainsights.com/Public/NewIssues.aspx>



## Medicare RAC Region B Web Site



[Home](#) [Issues](#) [Contact Information](#) [Providers](#) [Letters](#) [FAQs](#)

RACB::Issues

<u>Issue Name</u>	<u>Issue Type</u>	<u>Claim Types</u>	<u>States</u>	<u>Date Approved</u> ▼	<u>Details</u>
Knee Orthoses	Automated	DME	IL, IN, KY, MI, MN, OH, WI	5/3/2010	<a href="#">Details</a>
Amputation for Circulatory System Disorders Except Upper Limb and Toe MS-DRGs 239, 240, 241 (At this time, Medical Necessity is excluded from review)	Complex	Inpatient	IL, IN, KY, MI, MN, OH, WI	4/15/2010	<a href="#">Details</a>
Medical Unlikely Edit (MUEs) Outpatient	Automated	Outpatient Hospital	IL, IN, KY, MI, MN, OH, WI	3/24/2010	<a href="#">Details</a>
Medical Unlikely Edit (MUEs) Professional	Automated	Professional	IL, IN, KY, MI, MN, OH, WI	3/24/2010	<a href="#">Details</a>
CAD versus Unstable Angina MS-DRG 311 (At this time, Medical Necessity is excluded from review)	Complex	Inpatient	IL, IN, KY, MI, MN, OH, WI	3/12/2010	<a href="#">Details</a>
Cardiac Defibrillator Implantation MS-DRG 223, 225, 227 (At this time, Medical Necessity is excluded from review)	Complex	Inpatient	IL, IN, KY, MI, MN, OH, WI	3/12/2010	<a href="#">Details</a>

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## Issue Details

<b>Name</b>	Hospital to Hospital Transfer
<b>Number</b>	B000142009
<b>Description</b>	Identified MS-DRG inpatient claims improperly reported as a discharge to home rather than as a transfer to another hospital resulting in an overpayment to the transferring hospital. When a transferring inpatient prospective payment system (IPPS) hospital indicates to Medicare that the patient is being discharged to home, the transferring hospital receives a full MS-DRG payment. In these cases, the transferring hospital should have received a per diem payment rate when transferring a patient to another acute-care facility. An overpayment exists when both hospitals (the transferring hospital and the final discharging hospital) receive full MS-DRG payments.
<b>Claim Type</b>	Inpatient Hospital
<b>Issue Type</b>	Automated
<b>Overpayment / Underpayment</b>	Overpayment
<b>Dates of Service</b>	10/1/2007 - Open
<b>States</b>	IL, IN, KY, MI, MN, OH, WI

- [CMS Internet-Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 3, Inpatient Hospital Billing, Sections 20.1.2.4, Transfers, and 40.2.4, IPPS Transfers Between Hospitals](#)
- [CMS Internet-Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 25, Completing and Processing the Form, CMS 1450 Data Set, Section 75.2, FL-17, Patient Status, and FL 18, Condition Codes](#)
- [CMS Change Request 2934, Dated February 6, 2004, New Policy On Acute Hospital Transfer For Patients Who Leave Against Medical Advice](#)
- [CMS Change Request 2716, Dated August 1, 2003, New Common Working File \(CWF\) Edits to Ensure Accurate Coding and Payments For Discharge And/Or Transfer Policies Under Inpatient Prospective Payment System \(IPPS\)](#)

 574-575-501, 502-503 (IPPS) (at this time, complex inpatient  
 Medical Necessity is excluded from review.)

 MN, OH,  
 WI

12/7/2009

Details

RACB:Issues

## Issue Details

<b>Name</b>	Amputation for Circulatory System Disorders Except Upper Limb and Toe MS-DRGs 239, 240, 241 (At this time, Medical Necessity is excluded from review)
<b>Number</b>	B001072010
<b>Description</b>	The purpose of MS-DRG Validation is to determine that the principal diagnosis, procedures and all secondary diagnoses identified as CCs and MCCs are actually present, correctly sequenced, and coded. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all (MCC/CC) present during the admission that impact the stay. The POA indicator for all diagnoses reported must be coded correctly. Reviewers will validate for MS-DRG 239, 240, 241 principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.
<b>Claim Type</b>	Inpatient
<b>Issue Type</b>	Complex
<b>Overpayment / Underpayment</b>	Overpayment and Underpayment
<b>Dates of Service</b>	10/1/2007 - Open
<b>States</b>	IL, IN, KY, MI, MN, OH, WI
<b>Policy Related Links</b>	<ul style="list-style-type: none"> <li>• <a href="#">ICD-9-CM Coding Manual (for dates of service on claim)</a></li> <li>• <a href="#">ICD-9-CM Addendums and coding clinics</a></li> <li>• <a href="#">PIM Ch 6.5.3, Section A – C - DRG Validation Review</a></li> <li>• <a href="#">Present on Admission Indicator Systems Implementation</a></li> <li>• <a href="#">OIG - Monitoring the Accuracy of Hospital Coding (OEI-01-98-00420; 1/99)</a></li> </ul>
<b>Date Approved</b>	4/15/2010

Medical Necessity is excluded from review)

WI

IL IN

# Z-PIC and PSC Contractors

- Program Safeguard Contractor (PSC)
  - Created in 1996 to conduct Medicare program integrity activities
- Zone Program Integrity Contractor (Z-PIC)
  - Successor to PSC program
- Purpose: Dedicated to program integrity and handles such functions as audit, medical review and potential fraud and abuse investigations
- PSCs replaced with Z-PICs
  - Z-PICs cover an area covered by a MAC
  - Z-PICs also have access to Medicaid data

# Z-PIC Functions

- Medicare data analysis (discovery, detection, investigation, and overpayment projection)
- Medical Review (post-payment medical review and medical review to support fraud case development – Part A and Part B claims review)
- Medicare fraud investigation and prevention
- IT Systems for case and decision tracking and data warehousing;
- Interface with the Medicare contractors, the medical community (outreach and education), and law enforcement

# Z-PIC Process

- Review targets a specific provider for a specific issue
  - You are an outlier, and they are investigating fraud
- Auditors appear, often unannounced, asking to interview individuals and obtain copies of policies and procedures (in addition to records)
- Extrapolation frequently used
- Can make referral to OIG or DOJ if fraud is suspected
- Oversight: Get Law Department involved immediately!
  - Consider conducting a shadow audit under attorney-client privilege

# Responding to the Record Request

- Stamp Date and Time Received
- Train staff on identities of contractors
- Ensure that staff are aware of deadlines to submit records
- Ensure contractor is sending to the correct person/address
- Identify any internal issues causing delay in receiving the requests



# Responding to the Record Request (con't.)

- Document Management
  - Stamp number (Bates Stamp) on bottom of each page produced
  - Scan everything provided to contractor
  - Include a cover letter itemizing box contents: documentation or a CD
  - Send by certified mail or, if regular mail, complete an affidavit of service by mail



# Responding to the Record Request (con't.)

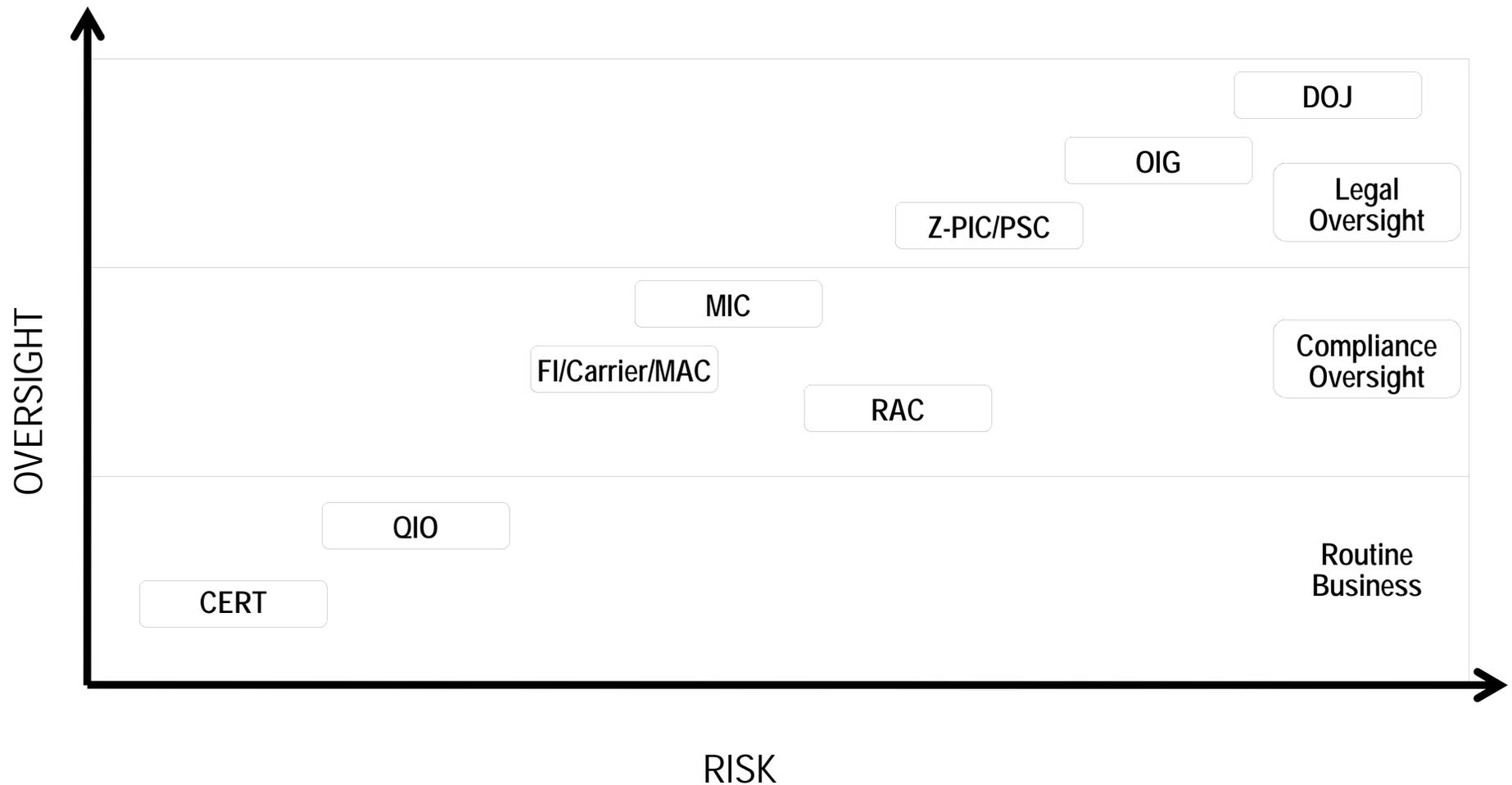
- Process Options
  - Treat as normal ROI request; HIM produces the records
    - Cost effective
  - Normal ROI process with some clinical review
    - Ensure entire record is copied
    - Include copies of NCD, LCD, coding guidelines, CMS guidance?
  - Shadow review of all submitted records
    - Resource intensive
    - Allows for early identification of issues
    - Establishes priority for appeals



# Responding to the Record Request (con't.)

- Software to Manage Records Produced
  - Does it help to manage the process or just store records?
  - Does it work with all types of audits, not just RAC audits?
  - Does it interface with your HIM or billing system?
  - Can compliance, legal, and other departments access the data?
  - Is it capable of producing a 'dashboard' for senior management review?

# Oversight by Compliance and Legal as Records are Submitted



# Defenses

- 1-year limit on reopening claims
- Limitation of Liability (Section 1879 of the Social Security Act)
- No Fault (Section 1870 of the Social Security Act)
- Treating Physician Rule
- Qualifications of Staff
- NCD or LCD is unlawful
- Should at least be paid an APC rate - or some amount - to reflect the outpatient services provided

## Defenses (con't.)

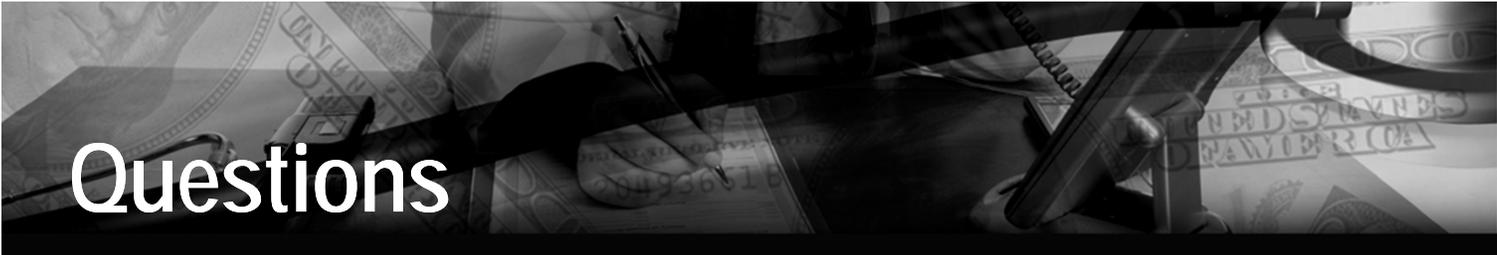
- Reviewer Used the Wrong Standards
  - Coding clinic, LCD, NCD, other CMS guidance
  - Note: QIC and ALJ are bound by laws and regulations, NCDs, and Medicare rulings, but not by other CMS guidance (such as Medicare Claims Processing Manual or Transmittals)
- Reviewer Applied the Standards Incorrectly
  - Review Medicare Ruling 95-1 on medical necessity standards
  - Support argument with affidavit/testimony of physician
  - Include any evidence of community standard
  - Include any scientific articles that support your position

# Special Appeal Issues

- Extrapolation
  - Federal Limitations on Extrapolation at 42 U.S.C. 1395ddd(f)(3):
    - A Medicare contractor may not use extrapolation to determine overpayment amounts for recovery by recoupment, offset, or otherwise, unless the Secretary determines that -
      - (A) there is a **sustained or high level of payment error**; or
      - (B) **documented educational intervention has failed** to correct the payment error

# Special Appeal Issues (con't.)

- Extrapolation Defenses
  - Methodology was flawed
  - Statutory limitation on extrapolation applies
    - Note: a determination by the Secretary of sustained or high levels of payment errors is not reviewable (by the District Court), but could be considered at lower levels
  - Another statistically valid sample from the same 'universe' of claims yields a different result



# Questions

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