

PHYSICIAN ADVISOR SERVICES

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ACCOUNTABLE CARE ORGANIZATIONS NOTICE OF REGULATIONS ISSUED

On March 31, 2011 several federal agencies issued regulations designed to facilitate Accountable Care Organizations (ACOs). ACOs are delivery mechanisms designed to coordinate care and centralize costs for care. USA Today quoted Health and Human Services Secretary, Kathleen Sebelius as stating that ACOs “could save Medicare \$960 million over the next three years...” She went on to say “for too long, it has been too difficult for healthcare providers to work together to coordinate and improve the care their patients receive. That has real consequences: patients have gaps in their care, receive duplicative care, or are at increased risk of suffering from medical mistakes. ACOs will improve coordination and communication among doctors and hospitals, improve the quality of the

care their patients receive, and help lower costs.”

The goal of ACOs is to provide vehicles for hospitals, doctors, other healthcare providers and suppliers to work together and coordinate care for Medicare beneficiaries. The proposed resulting savings would be shared if the ACOs meet quality standards in five areas:

- Patient/caregiver care experiences
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health.

Although the Patient Protection and Affordable Care Act provided for the shared savings program, other federal laws created challenges for the formation of ACOs. The federal guidance is intended to facilitate the implementation of ACOs and shared savings. The Centers for Medicare & Medicaid Services (CMS)

issued an advanced copy of the proposed rule available at <http://www.cms.gov/sharedsavingsprogram>, with the proposed rule to be issued on April 7, 2011. In addition, CMS and the Health and Human Services Office of Inspector General outlined proposals to make changes in the anti-kickback and Stark laws as they apply to ACOs. Public comment on the joint statement will be accepted until May 31, 2011. The joint statement, which is quite lengthy, is available at the office of the Federal Register and will be published in the Federal Register on April 7, 2011.

Finally, the Federal Trade Commission has also provided notice of changes to federal anti-trust enforcement in order to “maximize and foster opportunities for health care providers to innovate in both the Medicare and commercial

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markets and achieve for more consumers the benefits Congress intended for Medicare beneficiaries through the Shared Savings Program.” The link to this publication is www.ftc.gov/opp/aco/.

Although many groups are issuing statements in

support for the concept of ACOs, they are reserving judgment until after reading through the implementation details.

As you are planning integration strategies and coordination of physician activities, it is helpful to understand how the

government views these collaborative efforts. Business methodologies should be structured to comply with existing laws, and should be flexible enough to adapt to the changing regulatory landscape.

Region A-DCS

<http://www.dcsrac.com/IssuesUnderReview.aspx>

1-866-201-0580

Region B-CGI

<http://racb.cgi.com/Issues.aspx?st=1>

1-877-316-7222

Region C-Connolly Healthcare

http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

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<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>

866-590-5598 (Part A)

866-376-2319 (Part B)

RAC FAQs - EXCERPTS FROM CMS WEBSITE

Will Code N432 appear on the remittance advice for Recovery Audit Contractor (RAC) adjusted claims? CMS created code N432 to identify RAC adjusted claims;

however, CMS believes the code is being superceded in some of the systems by code N469 which is the Section 935 Limitation Recoupment code. We are working to correct this problem in the system. Providers will receive demand letters for all RAC adjusted claims. These

letters will allow providers to keep track of RAC adjustments versus all other claims processing adjustments.

Can the RAC do a medical necessity review on a claim that they originally reviewed for DRG validation?

Beginning November 1, 2010 if the RAC has already requested documentation and issued a review results letter to the provider for a DRG Validation, the RAC will be allowed to re-review the

claim again for medical necessity. However, if both issues are approved (DRG Validation and medical necessity) prior to the request of the additional documentation, the RAC may also conduct both reviews simultaneously. Each additional documentation request (ADR) is subject to the same review timeframes and counts toward the provider's ADR limit.

To view all of the CMS RAC FAQs, click [here](#).

CMS STRESSES IMPORTANCE OF CORRECTLY CODING PLACE-OF-SERVICE BY PHYSICIANS

In MLN Matters Number SE1104 Medicare stresses the importance of physicians correctly coding the place-of-service on Part B claims. Medicare Part B pays for services that physicians provide to Medicare beneficiaries, including medical and surgical procedures, office visits, and medical consultations. The services are appropriately provided in different settings such as hospital outpatient departments

and freestanding Ambulatory Surgical Centers (ASCs), or non-facility locations, such as physician offices, urgent care centers, and independent clinics.

The place of service has become an audit risk and findings from an OIG audit are available in a report titled “REVIEW OF PLACE-OF-SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY MEDICARE PART B CARRIERS DURING

CALENDAR YEAR 2007 and is available at: <http://oig.hhs.gov/oas/reports/region1/10900503.aspx>. The OIG reports that in many instances, physicians incorrectly coded the place-of-service using the non-facility place of service codes for services that were actually performed in hospital outpatient departments or ASCs. This practice can result in overpayments.



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