

PHYSICIAN ADVISOR SERVICES

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PROBE AUDITS IDENTIFY AREAS OF RISK

Many facilities are experiencing denials for short stays for MS-DRG's such as 392, Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders without MCC. You may recall that post pay probe claim reviews for MS DRG 392 findings were disturbing in the error rates that were reported. For example, Highmark Medicare Services reported that based on a review of 84 claims there was a 27% error rate in dollars paid for 392 in Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania. Of the 84 claims, 13 were denied based upon a determination that the services were not "reasonable and necessary", while 9 of the 84 records were not received by Highmark for review. As a result of the findings Highmark is now conducting a service wide pre-pay edit and medical review of acute inpatient hospital claims for DRG 392. Similar probe reviews have been conducted by Cahaba and Trailblazer. Trailblaz-

ers reported a 90.38% paid claims error rate on the sample of 100 claims reviewed.

The Highmark denials for the claims sampled during the post payment probe were based on the following criteria:

- The severity of signs and symptoms exhibited by the patient, and / or the intensity of service did not warrant an inpatient admission to an acute level of care.
- The medical predictability of something adverse happening to the patient was not supported by the documentation to warrant an inpatient admission.
- There was missing and/or insufficient documentation which was needed to perform the review.
- The documentation was not submitted.

Trailblazer reported similar reasons for denials and cited:

- Level of care not supported by medical records

- Incomplete documentation

As you can see from above the auditors claim that the documentation does not show the severity of risk that would warrant inpatient admission. Our experienced appeal staff note that with this type of case auditors frequently miss key clinical indicators of risk that would indeed warrant inpatient care. Indicators of risk are often very subtle and require complex medical judgment by a physician to identify. As a result it would behoove clients to have a medical doctor review the cases before conceding to recoupment. Hospitals may want to appeal many of the cases with sound clinical rationale written by an MD.

For additional information, please contact Ann Purdy at 205-314-8859 or by clicking [here](#).

HHS OIG WORK PLAN FY 2012- OBSERVATIONS



An excellent way to gauge what the Office of Inspector General (OIG) will be focusing on during this year is to review its Work Plan. The 2012 Work Plan continues many initiatives that have appeared in previous Work Plans. For example, a repeat from previous years include reviews centered around “Observation Services during Outpatient Visits.” This initiative reviews the appropriateness of the observation services and their effect on Medicare beneficiaries’ out-of-pocket expenses for the services.

Another example of a repeated focus is “Hospital Admissions with Conditions Coded Present on Admission” (POA). They will be reviewing Medicare claims to determine which type of facilities (such as SNF or rehabilitation facilities) most frequently transfer patients with

certain diagnoses that were coded as being present when the patients were admitted. They will also determine if specific providers transferred a high number of patients to hospitals with POA diagnoses. Along these same lines, a new initiative relates to review of the accuracy of the POA indicators submitted on the inpatient claims submitted by hospitals nationally in October, 2008. Since hospitals do not receive additional payment for certain conditions that were not POA the review is expected to identify hospitals that are not accurately coding the diagnoses. The Work Plan notes that certified coders will review medical records and Medicare claims.

Another review that is marked new but sounds old is for “Medicare Inpatient and Outpatient Payments to Acute Care Hospitals.” The

focus of this review is to determine if Medicare payments to hospitals are compliant with selected billing requirements. The reviews will be used to recommend recovery of overpayments and to identify providers that routinely submit improper claims. The OIG will use data mining techniques and data analytics to determine the hospitals that rank the least and most risky across compliance areas.

It is a good practice to be familiar with the OIG Work Plan so that you can make sure that your auditing and tracking measures are in place and adequate to identify areas of concern. Click [here](#) to access the entire 2012 Work Plan.

If you have questions about this article, please contact Ann Purdy at 205-314-8859.

RAC FAQs - EXCERPTS FROM CMS WEBSITE

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

1-866-360-2507

Region D-HDI

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

866-590-5598 (Part A)

866-376-2319 (Part B)

What is a semi-automated review? It is a two-part review that is now being used in the Recovery Audit Program. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has a high index of suspicion to be an improper payment. The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that was identified. The letter also indicates that the provider has 45 days to submit doc-

umentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued. However, if the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed.

What events or activities could lead to a Recovery Auditor blackout (transition) period? There will be a Medicare fee-for-service Recovery Auditor blackout period whenever a fiscal intermediary, carrier or MAC transitions to a new contractor. The length of the blackout period will vary dependent on each situation and will be communicated to the affected providers. To view all of the CMS RAC FAQs, click [here](#).