

PHYSICIAN ADVISOR SERVICES

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ICDs: ON THE AUDIT RADAR SCREEN

In our October 2010 newsletter, we discussed the need for hospitals to closely monitor National Coverage Determinations (NCDs) related to implantable cardiac defibrillators (ICDs). In the current environment, hospitals should prepare for possible increased scrutiny regarding the medical necessity of ICD procedures. In late 2009 the United States Department of Justice (DOJ) announced an investigation into the medical necessity of the swelling number of ICD implantations across the nation. These cases create a particularly high financial risk for hospitals for multiple reasons. First, many ICD procedures are done in the inpatient level of care, which allows for two audits wrapped in one. The DOJ can first review the necessity of the ICD implantation as well as the necessity for inpatient admission. Most ICD procedures are not on the inpatient-only list. Second, an NCD controls the definition of medical necessity on this issue.

To put the issues around ICDs in perspective it is important to understand the evolution of the coverage issues. NCD, CMS 20.4, has been in place since 1996, but has been revised

several times. In 2003, in particular, it became very technical and detailed. In fact, the DOJ plans to review cases from 2003 forward. Since this NCD will be given full deference by the auditors and administrative law judges, full compliance with all of its details is a must. Finally, the NCD requires further documentation to support the implantation of any ICD with more than a single lead. Since a substantial number of ICDs placed in the last several years have been dual chamber or biventricular devices, hospitals may have to prepare for an audit on this level as well.

Given the intense documentation requirements for ICD placement, we recommend hospitals gather as much data as possible from the attending cardiologist's office to include in the hospital's medical record. Some of the information needed includes evidence of past MI, specific dates of past cardiac interventions, the most recent EF and the specific technology used to measure it, evidence of prior arrhythmias (particularly bradycardia events that would support dual chamber pacing), and recent EKGs with interval

measurements.

In addition to meeting very specific clinical requirements, the patient, in most circumstances, must NOT have:

- ▶ Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm;
- ▶ Had a CABG or PTCA within the past 3 months;
- ▶ Had an acute MI within the past 40 days;
- ▶ Conical symptoms or findings that would make them a candidate for coronary revascularization;
- ▶ Any disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than one year.

Facilities should make certain that ICD services were billed in accordance with applicable NCDs and as with all billing errors, actions should be undertaken to timely correct billing errors and to prevent ongoing billing issues.

If you would like more information regarding this article please contact Dr. Gregory Palega at gpalega@medmanagementllc.com or Ann Purdy at apurdy@medmanagementllc.com.

AHA URGES CMS TO EXEMPT SOME STATES FROM MEDICAID RAC PROGRAM

Link to AHA Letter:
<http://www.aha.org/aha/letter/2010/101220-cl-cms->



In a letter dated December 20, 2010, the American Hospital Association (AHA) has asked CMS to exempt from the Medicaid Recovery Audit Contractor (RAC) program states that have existing Medicaid Integrity Programs (MIPs) or other Medicaid audit programs. The letter addressed to Donald M. Berwick, MD, CMS Administrator from AHA Executive Vice President Rick Pollack, is in response to the proposed rule implementing provisions in the Patient Protection and Affordable Care Act (ACA) related to the Medicaid RAC program.

In the letter Mr. Pollack states that "hospitals strive for payment accuracy and are committed to working

with their state Medicaid program and its contractors to ensure validity of Medicaid payments." The letter continues by stating that "providers in many states work with their Medicaid agencies to identify inappropriate payments by participating in the MIP or similar Medicaid audit programs." These programs, very similar to the Medicaid RAC program, have proven to be effective in identifying and recouping improper payments. There is concern that the "Medicaid RAC program will result in duplicative audits and will add yet another layer of disruptive and costly administrative burden for both the agency and the provider community."

The exemption was also requested for states that operate Medicaid managed care programs since in these states providers are already subject to audits by private managed care organizations (MCOs)

In states where CMS requires implementation of a Medicaid RAC program, CMS was urged to not repeat mistakes that were made during the Medicare RAC demonstration program.

To read the entire letter, click [here](#).

If you have questions regarding the Medicaid RAC program, please contact Ann Purdy by clicking [here](#) or call her at 205-314-8859.

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)

RAC FAQs - EXCERPTS FROM CMS WEBSITE

Will the Recovery Audit Contractors (RAC) appeal process mirror the regular Medicare appeal process?

The Medicare Appeals process will remain the same for physicians under Part B and Part A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the Prospective Payment System (PPS). In the current appeals process, the first level appeal will go to the Quality Improvement Organization (QIO); however, the RAC appeals will go to the Fiscal Intermediary

that processed the claim.

Do Recovery Audit Contractors (RAC)s look for underpayments? What happens if they find an underpaid claim?

Yes, Recovery Audit Contractors will identify underpayments as well as overpayments. In situations where a RAC identifies both overpayments and underpayments for a provider, the RACs offset the underpayment from the overpayment. In situations where a RAC identifies an underpayment for which there is no overpay-

ment from which to offset, the RACs will inform the carrier or intermediary who will proceed with the claim adjustment and payment to provider. A MLN Matters article, SE0617, was released 4/10/2006 with additional information for providers concerning the identification of an underpayment by a RAC. The MLN Matters article can be found at www.Cms.hhs.gov/MLNMatters/articles/download/SE0617.pdf.

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

Happy New Year Happy New Year Happy New Year