

# PHYSICIAN ADVISORY SERVICES

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## RAC MEDICAL NECESSITY REVIEWS ON THE HORIZON

As the Recovery Audit Contractors (RACs) have posted CMS approved issues on their websites, many have asked if and when medical necessity reviews can be expected. The uncertainty was addressed during the May 5 nationwide RAC 101 call when Scott Wakefield, project officer for CMS stated that providers may begin to see medical necessity reviews “within the next month or so.” Although no specific timeline was given, providers were put on notice that the reviews are on the horizon. The RACs started with the automated reviews and then moved to the complex reviews for coding and DRG validation. The speculation is that the medical necessity reviews have been delayed because of the subjective manner in which “medical necessity” is defined.

Documentation is the key to avoiding recoupment due to lack of medical necessity. One area

that is problematic for providers is documenting the rationale for level of care decisions. Interqual and Milliman criteria based screening tools are not necessarily determinative factors under Medicare law, rather the Medicare manuals provide the factors to be considered when making the decision on whether to admit a patient. The factors are detailed in Chapter 1 of the Medicare Benefit Policy Manual and include the following:

- 1) The patient’s medical history and the severity of the signs and symptoms that affect the medical needs of the patient,
- 2) Medical predictability of something adverse happening to the patient,
- 3) Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at

the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted,

- 4) Availability of diagnostic procedures at the time when and at the location where the patient presents.

Providers can prepare for the RAC medical necessity reviews by being proactive and putting processes in place to make and document correct level of care decisions. Addressing the factors that determine the appropriateness of the level of care is critical to avoid RAC recoupment.

Physician advisors are an effective resource in making the level of care decision. Physician advisors trained in the CMS guidelines and regulations can assist attending physicians in complying with CMS regulations so billing is accurate.

For more information contact Ann Purdy at [apurdy@medmanagementllc.com](mailto:apurdy@medmanagementllc.com).

## RAC FAQs - EXCERPTS FROM CMS WEBSITE

### Region A-DCS

<http://www.dcsrac.com/issues.html>

### Region B-CGI

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

### Region C-Connolly Healthcare

[http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)

### Region D-HCI

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

### What is the name and contact information for each Recovery Audit Contractor (RAC)?

Region A: Diversified Collection Services (DCS) -1-866-201-0580, [www.dcsrac.com](http://www.dcsrac.com)

Region B: CGI -1-877-316-7222, e-mail: [racb@cgi.com](mailto:racb@cgi.com), <http://racb.cgi.com>

Region C: Connolly Consulting, Inc. -1-866-360-2507, [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC), [RACinfo@connollyhealthcare.com](mailto:RACinfo@connollyhealthcare.com)

Region D: HealthDataInsights, Inc.-Part A: 866-590-5598, Part B: 866-376-2319, e-mail: [racinfo@emailhdi.com](mailto:racinfo@emailhdi.com)

*(This question was originally published 7/19/2006 and updated 5/18/2010)*

## CLINICAL REVIEW JUDGMENT CLARIFIED IN CMS PUB 100-08 TRANSMITTAL 338, CHANGE REQUEST 6954

To read the CMS MLN Matters article about CRJ click here: <https://www.cms.gov/MLNattersArticles/downloads/MM6954.pdf>



Change Request 6954 instructs Medicare claim review contractors to use clinical review judgment (CRJ) when making complex review determinations about a claim. The CRJ involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Medicare claim review contractors are identified as carriers, fiscal intermediaries (called affiliated contractors,

or ACs), Medicare Administrative Contractors (MACs), the comprehensive error rate testing (CERT) contractor, program safeguard contractors (PSCs) zone program integrity contractors (ZPICs) and recovery audit contractors (RACs). These contractors are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

In chapter 3 of PUB 100-8 Medicare Program Integrity it states, "The CRJ does not replace poor or inadequate medical records. CRJ by definition is not a process that ACs, MACs, CERT, RACs, PSCs and ZPICs can use to override supercede or disregard a pol-

icy requirement. Policies include laws, regulations, CMS rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations.

It should be noted that in the decision of inpatient vs. outpatient (observation) services, traditional screening criteria such as Interqual and Milliman are not endorsed. Therefore, the contractors must rely on the policies that are noted above in making judgments regarding the decision to admit. The CMS guidelines clearly indicate that "complex medical judgment" is required to make the decision.

To read the transmittal in its entirety click the link below.

<http://www3.cms.gov/transmittals/downloads/R338PI.pdf>.

## JOAN RAGSDALE DISCUSSES HEALTH CARE REFORM

Joan Ragsdale was a panelist for a Birmingham Business Journal sponsored event focused on the Health Care Reform Bill. The panel discussion was held in Birmingham,

Alabama on April, 29, 2010 at the Harbert Center. The panel discussed the potential effects of the Health Care Bill on small businesses, consumers and providers. Click the fol-

lowing link to view a synopsis of the discussion.

<http://birmingham.bizjournals.com/birmingham/stories/2010/04/26/daily32.html>.