

# PHYSICIAN ADVISOR SERVICES

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## DOCUMENTATION REQUIREMENTS

Has a physician ever asked, “what do you want me to document?” Many times in the hospital setting we talk about improving documentation but we do not specifically communicate what that means. When you think about it, it should not be difficult and can be summed up by asking the physician to articulate data pertaining to patients related to six areas of care.

**1) Services were actually provided** – Although this item seems obvious it is a good reminder that if it is not in the medical record, for regulatory purposes it did not happen.

**2) By whom and when** – Clearly state who provided the care and the time it was provided.

**3) Medically necessary** – For Medicare purposes the definition of “medically necessary” is that the care was “reasonable and necessary for diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.”

Therefore, the medical record should tell the story of how the care that was provided was needed for diagnosis and treatment of the patient.

**4) Appropriate level of care** – There are two settings of care in hospitals, inpatient and outpatient. Observation is a service provided not a setting or status. The definition of an inpatient is as follows: “An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.” The key to this definition is to document the physician’s expectation that the patient will be receiving inpatient services

overnight (or 24 hours in other regulatory citations.)

**5) Professional standard of care** – This category asks whether a professional with the same or similar training and experience would provide the same or similar care. You also look at what the community standards are in regards to the care.

**6) Quality** – CMS is charged with protecting its beneficiaries. Accurate and concise documentation should support the services provided and clearly demonstrates the quality of the services.

As mentioned above, we talk about the importance of telling the story. The areas of focus as described give a guideline to physicians for good, clear and concise documentation.

For more information about this article, contact Ann Purdy by clicking [here](#) or call her at 205-314-8859.



## MEDICAID RACs

Audit activity through existing agencies and initiatives will continue to increase in 2012, but it is important to remember that in addition to an expansion of current initiatives there will be a new auditing entity in 2012. Unless a state has been granted an exception, the state must implement a Medicaid RAC program by January 1, 2012. These Recovery Audit Contractors will be different entities than the Medicare RACs and will abide by different rules. Each state will set limits on the number of records

that can be reviewed and the frequency of those record requests.

There is broad discretion with the operational aspects of the program so we anticipate that each state's protocols and processes for review and resolution will vary. The appeal rights will be governed by state law and state administrative procedures. The Medicaid RACs are required to coordinate their activities with other auditing entities and they are not supposed to audit claims that have already been audited or

that are currently being audited by another entity. It is important that each facility inform RAC committee members, compliance and appropriate staff of the Medicaid RAC for the state, and share processes and policies as those are shared with the provider community.

Click [here](#) to be linked to the final ruling in the Federal Register.

If you have any questions, please contact Ann Purdy at 205-314-8859 or email her by clicking [here](#).

### 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](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

***Are my claims exempt from Recovery Auditors review if I am participating in a CMS demonstration?*** At times CMS does grant temporary exemptions from RAC review for CMS sponsored demonstrations. However, all demonstrations do not get an exemption. The demonstration contractor or CMS will alert providers if their claims are exempt from RAC review during the demonstration. This alert can usually be found in the initial welcome letter. Questions can be directed to the contractor performing the demonstration.

***Has CMS published the Medically Unlikely Edit (MUE) values for Health Common Procedure coding System (HCPCS)/Current***

### ***Procedural Terminology (CPT) codes?***

CMS publishes on its website most MUE values. However, CMS does not publish MUE values for some codes. The MUE values for this latter group of codes are confidential information that should not be published by third parties who have acquired them.

MUE values are not utilization guidelines. Providers may be subject to a review of their claims by claims processing contractors, program safeguard contractors (PSCs) or recovery audit contractors (RACs) even if they report units of service less than or equal to the MUE value for the HCPCS code.

What happens if the recov-

ery auditor does not meet the 60 day requirement? The recovery auditors have 60 days from receipt of the medical records to make a determination and issue a written notice of that determination to providers. The 60 day requirement can be found in the Statement of Work used in the Recovery Audit Program. Lack of adherence to the 60 day requirement of notification does not negate the improper payment finding or the recoupment of the improper payment by CMS. Lack of adherence to the 60 day requirement is a performance issue between CMS and the recovery auditor.

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