

PHYSICIAN ADVISOR SERVICES

INSIDE THIS ISSUE:

“Default” Level or Care Orders	1
Straight from MLN Matters	3
RAC FAQs - Excerpts from CMS Website	3
Ragsdale to Speak in Baltimore, 9/27	3

QUICK MEDMANAGEMENT CONTACT LIST:

Joan Ragsdale, 205-970-8804
jragdale@medmanagementllc.com

Ann Purdy, 205-314-8859
apurdy@medmanagementllc.com

Pam VanEngelenhoven, 205-970-8815
pvanengelenhoven@medmanagementllc.com

Gregory Palega, MD, JD, 205-313-6648
gpalega@medmanagementllc.com

Questions? Contact us at:

MedManagement, LLC

1500 Urban Center Drive

Suite 325

Birmingham, AL 35242

205-970-8800

Contact our UM Staff:

Toll Free at 1-866-298-1603

Visit our website at:

www.medmanagementllc.com

“DEFAULT” LEVEL OF CARE ORDERS

Case managers and utilization management staff try hard to make certain there is appropriate documentation for each level of care order, but frequently find that significant time has elapsed between the physician’s initial orders and the time the first review occurs. In order to address the time delay some hospital staffs have encouraged physicians to order observation services (OBS) until a review can be completed. It is important that facilities put processes in place to get the correct level of care documented on presentation and **NOT** to default to a level of care determination. Defaulting to “OBS” has often been the default order of choice because the overuse of observation services never results in recoupment on audits. However, overuse or inappropriate use of observation services can negatively impact the facility and the beneficiary.

In a July 7, 2010 letter to the American Hospital Association the Acting Administrator of CMS raised concerns about the overuse of observation services and noted: “Observation care of more than 24 hours can have tremendous impact on Medicare beneficiaries. For

example, Medicare beneficiaries are liable for approximately 20 percent of the costs of outpatient services that are paid by the Medicare Part B program while the patient is receiving observation, and, in some situations, the full costs of self-administered drugs provided during that time. Further, a beneficiary must stay in the hospital a minimum of 3 days as an inpatient before Medicare will pay for skilled nursing facility care; prolonged outpatient encounters do not count towards this statutory requirement.” Thus, CMS has become increasingly concerned about patients receiving observation services for longer periods of time.

Hospitals are also concerned about increasing observation services. Where there is an overutilization of observation services, hospital reimbursement is adversely affected. There may also be an increase in a hospital’s ALOS since short inpatient stays have been inappropriately billed as “observation services” rather than short admissions. The length of stay numbers are often viewed as quality indicators and so inappropriate use of observation affects both quality and finan-

cial indicators.

Some facilities have been reluctant to admit a patient who will require overnight or 24 hour services until test results are returned that verify the suspected diagnosis. However, the Medicare Benefit Policy Manual is clear that the physician’s “complex medical judgment” should be a good faith determination of whether it is anticipated that the patient will need inpatient services overnight even if results or events subsequent to that determination allow the patient to be discharged in less than 24 hours. The initial order should be based on the physician’s assessment of the level of care needed at the time the order is written, and whether the physician believes the patient requires inpatient services overnight or for greater than 24 hours. To “delay” the order by arbitrarily writing OBS orders may result in significant overuse of OBS services. Every effort should be made to get the appropriate order entered promptly. “Default” orders create documentation, financial and quality issues for facilities and potentially for the patients they serve.

STRAIGHT FROM MLN MATTERS

Here is the link to the MLN Matters 7436:

<https://www.cms.gov/MLN MattersArticles/downloads/MM7436.pdf>

On July 29, 2011 MLN Matters Number MM7436 was released. It stated the following. "As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will

submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and

the appeals process. However, the Medicare contractor will include the name of the initiating Recovery Auditor and his/her contact information in the related demand letter. You should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment."

If you have questions, please contact Ann M. 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.connolly.com/healthcare/pages/ApprovedIssues.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

When will there be a Recovery Audit blackout (transition) period? There will be a Medicare fee-for-service Recovery Audit blackout whenever a fiscal intermediary, carrier or MAC transitions to a new carrier. The length of the blackout period will vary dependent on each situation and will be communicated to the affected providers.

What is the length of the Recover Audit Contractor (RAC) discussion period? The discussion period be-

gins with the time of notification (demand letter for automated review and the review results letter for complex reviews) through the time recoupment occurs. The discussion period normally requires written notification to the RAC. The discussion period does not extend the provider's appeal timeframes.

Will all self-audited claims be excluded from a RAC review if, prior to the review, a provider has performed a self-audit and wants to extrapolate these

findings?

If a provider self-discloses a payment error and the Claims Processing Contractor confirms that a payment error exists and the sampling/extrapolation methodology used was correct, then these claims will not be reviewed by the RAC. The claims processing contractor will exclude the self-disclosed claims in the RAC data warehouse.

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

RAGSDALE TO SPEAK IN BALTIMORE, 9/27

Joan Ragsdale is scheduled to speak on September 27, 2011 at the Fraud & Compliance Forum in Baltimore, Maryland. The conference is jointly sponsored by the

Health Care Compliance Association (HCCA) and the American Health Lawyers Association (AHLA). She will co-present with Timothy P. Blanchard, MHA, JD. The title

of the presentation is "Medical Necessity Documentation to Meet Reimbursement Requirements and Avoid Fraud Allegations."



ACCREDITED
HEALTH UTILIZATION
MANAGEMENT