Prepayment Reviews: Understanding Audit Targets and Reducing Risks

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Why Prepayment Audits?

- Medicare – 47.5 million enrollees in 2010
- $523 billion paid out for services
- 4.5 million claims processed per day
- Estimated 10.5% error rate = $34.3 billion
  ✓ (the numbers never match- it’s the government)

- $1.9 billion budgeted for program integrity activities in 2012
  - Medicare Program Integrity Report to Congress
  - June 23, 2011
What About Part C and D?

- 2009- MA plan error rate- 15.9% or $12 billion
  - Improper severity ranking of beneficiaries
  - RADV audits ongoing

- Part D error rate- 12.7% or $8.4 billion

- Turnabout is fair play- these are overpayments by CMS to insurers and PBM’s!
Clean Claim Law

- Social Security Act (SSA) § 1816(c)(2)
  - 95% of all non-PIP, clean claims must be paid within 30 days
  - Interest must be paid on claims not paid within 30 days
  - Records subject to non-random pre-pay audit are considered “non-clean”
Authority for Prepayment Audits

• Section 934 of Medicare Modernization Act
  ✓ Allows Medicare contractors to conduct audits
    ➢ Random- to determine error rate
    ➢ Non-random- when there is the likelihood of a sustained or high error rate
What Triggers a Prepayment Audit?

- Claims data comparisons
- Utilization pattern analysis
- Beneficiary complaints
- Other hospital/physician/ASC complaints
- OIG report/inquiry
- Government Accountability Office reports
- Department of Justice investigations
Should We Be Offended By This?

• Absolutely!

• “These proposed demonstrations seek to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments by developing methods to investigate and prosecute fraud. In fact, these demonstrations would add to the efforts that CMS and its partners have taken in implementing a series of anti-fraud initiatives in high-risk fraud states.” (emphasis added)
  
  CMS Supporting Statement  CMS-10421, OCN: 0938-NEW
On To The CMS Prepayment Demonstration Project

- Initial announcement November 15, 2011 to start January 1, 2012
- States with high fraud- and error-prone providers
  - FL, CA, MI, TX, NY, LA, IL
- States with high claim volumes of short stays
  - PA, OH, NC, MO
- Also announced the “Scooter Store” Prior Authorization Demonstration Project
  - Venue changed to Federal Prison
Why a Demonstration Project and Not Just a MAC Duty?

- “CMS is limited by the amount of funding we get for medical review and so, you know, one way to conduct additional review, you know, that’s a different funding stream is used, you know, Recovery Audit Contractor Program.”

  - Connie Leonard, teleconference, August 9, 2012
Prepayment issues to be phased in:

- Aug 27, 2012: MS-DRG 312 Syncope
- Jan 1, 2013: MS-DRG 069 TIA (per RAC)
- TBD: MS-DRG 377 G.I. Hemorrhage w MCC
  MS-DRG 378 G.I. Hemorrhage w CC
  MS-DRG 379 G.I. Hemorrhage w/o CC/MCC
- TBD: MS-DRG 637 Diabetes w MCC
  MS-DRG 638 Diabetes w CC
  MS-DRG 639 Diabetes w/o CC/MCC
• Additional Documentation Requests come from the MAC with address to send records
• RAC reviews records and communicates payment determination to the MAC
• Records sent to MAC in error will be sent to the RAC for review
• Providers have 30 days to send documentation. If 30-day window missed, MAC does complex review.
• Providers receive determination on their remittance advice within 45 days
• RAC sends detailed review results letter
• MAC responsible for processing and payment
• For now, limits on prepayment and post-payment reviews won’t **typically** exceed current post-payment ADR limits

  ✓ “And what that means is if your current ADR limit for Recovery Auditor post-payment review is 400, then the Recovery Auditor will *do their best* to make sure that your prepayment reviews and post-payment reviews don’t exceed 400.”

• Providers may appeal the denial

• Same appeal rights as other denials

• Claims will be off-limits from future post-payment reviews by a CMS contractor
What About Syncope?

- DRG 312- syncope and collapse

- What to do:
  - Talk to your coders to double check syncope charts for good documentation. Use physician queries.
  - Did the physician indicate the symptom as the primary diagnosis rather than the underlying cause that was discovered after evaluation?
• Did your doctors document well?
  ✓ Comorbid conditions
  ✓ Events leading up to episode
  ✓ Associated symptoms
  ✓ All abnormals on labs and EKG
  ✓ Did they do orthostatic vital signs?
    ➢ Single most important test in syncope
Risk Stratification Tools

- **ROSE – Risk Assessment of Syncope in ED**

- BNP concentration of at least 300 pg/mL (odds ratio 7.3).
- Positive rectal exam for fecal occult blood in patients with suspected gastrointestinal bleeding (OR 13.2).
- Hemoglobin no greater than 90 g/L (OR 6.7).
- Q waves on electrocardiogram (but not in lead III) (OR 2.8).
- Left bundle branch block on electrocardiogram (OR 4.8).
- Oxygen saturation no greater than 94% on room air (OR 3.0).
• San Francisco Syncope Rule
  ✓ Any one of these = high risk
  
  • C - History of congestive heart failure
  • H - Hematocrit < 30%
  • E - Abnormal ECG
  • S - Shortness of breath
  • S - Triage systolic blood pressure < 90
Will Decision Tools Avoid Denials?

• The use of a decision tool will demonstrate to the auditors that the physician used evidence-based literature to make an assessment of “the medical predictability of something adverse happening to the patient.”

• (Nothing will avoid denials— the RAC’s are paid to deny!)
Transient Ischemic Attack

- Audits began January, 2013

- Once again, do your doctors document history and risk factors?

- Who should be admitted with a TIA?
  - By definition they are stable on presentation so the decision is based on the medical predictability of something adverse happening to the patient

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Risk Stratification

- ABCD2 Score
Future DRG’s

• GI hemorrhage – 377-379
  ✓ GM LOS 2.4 to 4.9 days

• Why is this a target?
  ✓ It’s anyone’s guess– it’s usually volume and money

• What’s the issue?
  ✓ ED doctors are not comfortable discharging patients with bleeding, fearing lack of followup and delay in diagnosis
What To Do

- CM screening of GI bleeds in the ED
  - It’s not all about the Hemoglobin
  - Be sure they check orthostatic vital signs
    - Indirectly measures rate of blood loss
  - Use criteria; if fail refer for secondary review
  - Hemodynamically stable low risk patients should be placed on observation or discharged for outpatient followup
  - Involve your CM in outpatient followup if discharged from ED
• Another “why this?” target
• Not all high glucoses are DKA

• Another case of ED doctors unwilling to discharge a patient, here with a high glucose
  ✓ “ED docs are from Venus, PCP’s are from Mars”
    ➢ In the office we see patients presenting with glucoses of 300-400 and treat as them in the office with medication
    ➢ In the ED a glucose over 300 almost always buys the patient a night in the hospital
What To Do

• If the only reason the ED doc wants to admit the patient is a high glucose, use your criteria and physician advisor secondary review process

• Work with your endocrinologists to avoid a million dollar workup in house; stabilize and discharge
MAC-Specific Prepayment Audits

Guess which MAC is especially vigilant?
FCSO DRG Targets

- 226 -- Cardiac defibrillator implant without (w/o) cardiac catheter with (w/) major complications or comorbidities (MCC)
- 227 -- Cardiac defibrillator implant w/o cardiac catheter w/o MCC
- 242 -- Permanent cardiac pacemaker implant w/MCC
- 243 -- Permanent cardiac pacemaker implant w/CC
- 244 -- Permanent cardiac pacemaker implant w/CC or MCC
- 245 -- Automatic implantable cardiac defibrillator (AICD) generator procedures
- 247 -- Percutaneous cardiovascular procedure w/drug eluding stent w/o MCC
- 251 -- Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC
• 253 -- Other vascular procedures w/CC
• 264 -- Other circulatory system or procedures
• 287 -- Circulatory disorders except acute myocardial infarction (AMI), w/cardiac catheter w/o MCC
• 458 -- Spinal fusion except cervical w/spinal curve, malign, or 9+ fusions w/o CC
• 460 -- Spinal fusion except cervical w/o MCC
• 470 -- Major joint replacement or reattachment of lower extremity w/o MCC
• 490 -- Back and neck procedures except spinal fusion w/CC/MCC or disc device/neurostimulator
MS-DRG 470 -- Major joint replacement or reattachment of lower extremity w/o MCC

- Applicable NCD/LCD: **LCD L32078**
- Error findings:
- CERT error findings:
  - In 92 percent of these cases, the documentation did not support that the procedure was reasonable and necessary.
  - In eight percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care (the billed knee replacement procedure code was not on the inpatient-only list).

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First Coast prepayment review findings:

- 30 percent prepayment edit implemented on June 1, 2011, with a 62 percent denial rate to date.
- Most were denied as the documentation did not support that the procedure was reasonable and necessary.

- First Coast denial rate for October-December 2012: 14 percent
“Effective February 1, 2012, FCSO will also perform post-payment review/recoupment of the admitting physician’s and/or surgeon’s Part B services.”

- If care should have been as an outpatient, FCSO will pay physician at outpatient level.
- If lack of documentation to support the care, payment will be denied.

First Coast Service Options LCD L32078
Re: OVERPAYMENT RECOUPMENT ACTION

Beneficiary Name: [Redacted]
HIC: [Redacted]
ICN: [Redacted]
Date(s) of Service: [Redacted]

Dear Provider:

First Coast Service Options, Inc. (FCSO) serves as the Medicare Administrative Contractor (MAC) for Jurisdiction 9 (J9) which includes Florida, Puerto Rico and U.S. Virgin Islands. One of the primary responsibilities of the MAC is to prevent improper payments. The Centers for Medicare and Medicaid Services utilize the Comprehensive Error Rate Testing (CERT) program to measure improper payments made by the Medicare Fee-for-Service program. For more information regarding the CERT program, you can go to the following FCSO link: http://medicare.fcso.com/Landing/203608.asp.

One of the primary drivers of CERT payment errors nationally and in J9 involves inpatient hospital services where the patient was admitted for an inpatient procedure or required a procedure during hospitalization and documentation submitted by the hospital (e.g., physician H&P, progress notes, operative reports, etc.) failed to support medical necessity for the procedure. In some cases, the procedure(s) in question is subject to medical necessity requirements defined in national coverage determinations (NCD) and/or local coverage determinations (LCD). For more information on this issue go to http://medicare.fcso.com/CERT/index.asp and click on the link for “Improper Payments and Inpatient Prepayment Medical Review.”

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 180 states that services “related to” noncovered services, including services that are not covered because they are determined to be not reasonable and necessary, are not covered services under Medicare. Therefore, FCSO has initiated overpayment recoupment of the Part B services performed by the surgeon, co-surgeon and assistant surgeon (as applicable) for the patient on the above identified date of service based on a medical necessity denial of the corresponding inpatient DRG claim.

This letter serves to notify you of the intent to recoup Part B payment. This is not an overpayment demand letter. You will receive the overpayment demand letter which includes your appeal rights in a future correspondence.
• 30% prepayment review for
  ✓ DRG 313 (chest pain) and
  ✓ DRG 552 (medical back) services
• 10% prepayment medical review for
  ✓ DRG 392 (esophagitis, gastroenteritis, and miscellaneous digestive w/o MCC) and
  ✓ DRG 641 (nutritional miscellaneous metabolic disorder w/o MCC)
• 153 – Otitis media and URI w/o MCC
  ✓ (CERT: 100% admission not necessary)
• 328 -- Stomach, esophageal & duodenal procedure w/o CC/MCC
  ✓ (CERT: 50% admission not necessary. 50% procedure not necessary)
• 357 -- Other digestive system O.R procedure w/ CC
  ✓ (CERT: 100% admission not necessary)
• 455 -- Combined anterior/posterior spinal fusion w/o CC/MCC
  ✓ (CERT: Procedure not reasonable and necessary)
• 473 -- Cervical spinal fusion w/o CC/MCC
  ✓ (CERT: 100% procedure not necessary)
• 517 -- Other musculoskeletal system and connective tissue O.R procedure w/o CC/MCC
  ✓ (CERT: 100% admission not necessary)
• MS-DRG 227 -- Cardiac defibrillator implant w/o cardiac catheter w/o MCC  Applicable NCD/LCD: NCD 20.4

• CERT error findings:
  • 70 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care.
  • 20 percent did not meet the NCD criteria for the procedure, and the admission was not reasonable and necessary for an inpatient level of care.
  • 10 percent did not meet the NCD criteria for the procedure, but the admission was reasonable and necessary for an impatient level of care. The admission allowed with a revised DRG code after removal of the denied procedure- Surgical DRG becomes Medical DRG
  • First Coast denial rate for October-December 2012: 36 percent
Defibrillators

• NCD 20.4
  ✓ Clear guidelines
  ✓ Matches HRS guidelines for medical necessity (unlike pacemaker NCD that is out of date)

• Medtronic/St. Jude/Boston Scientific does not waive the cost of the device if hospital gets denied!

• Develop a checklist- no pass→no device (or ABN/HINN)
• Elective placement = Outpatient unless
  ✓ Documented comorbidities
  ✓ Unstable medical condition
  ✓ Active anticoagulation
  ✓ Then can admit as inpatient pre-procedure
• Noridian
  ✓ Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of spinal orthoses L0631 and L0637.
  ✓ The L0631 review involved 101 claims of which 96 were denied, resulting in an overall error rate of 96%, while the L0637 review involved 100 claims of which 80 were denied, resulting in an overall error rate of 80%.
Doctors Are Not Immune

- Data analysis indicates a significant upward trend in CERT errors for Subsequent Hospital Care services. Present time trending indicates that the CERT errors for subsequent hospital visits will double in May 2012 in comparison to May 2011 for J5.
- Claims for CPT Code 99233 (high level subsequent hospital visit) in J5 will be randomly selected to determine if the service(s) was documented, coded correctly and the medical necessity supports the level of service billed.
• In an effort to reduce the Part B CERT error rate, National Government Services (NGS) will be performing a service-specific prepayment audit on certain CPT codes.
• The services and CPT codes on prepayment review are:
  • General Surgery: 99223-Initial Hospital Care
  • Cardiology: 99233-Subsequent Hospital Care
  • Gastroenterology: 99233-Subsequent Hospital Care
  • Hematology/Oncology: 99215- Office or other Outpatient Visit for an established patient
The table below provides you with a list of the most current prepayment reviews being conducted by the Part B Medical Review Department. This is not an all inclusive list.

- Air Ambulance; Hospital to Hospital Transport A0431, A0430, A0435, A0436
- Ambulance Service; ALS, Emergency A0427
- Ambulance Service; BLS, Non-Emergency A0428
- Ambulance Service; BLS, Emergency A0429
- Complete Blood Count (CBC) with Differential 85025
• Critical Care; E&M 99291-99292
• Emergency Department Visit; E&M 99285
• Initial Hospital Care; E&M 99223
• Office Visits; Established Patient; E&M 99214-99215
• Physical Medicine and Rehabilitation Services All Codes
• Psychotherapy, Individual, Inpatient 90816-90818
• Sensory Nerve Conduction Studies 95904
• Subsequent Hospital Care 99233
• Subsequent Nursing Facility Care 99308-99310
PALMETTO GBA RESUMES SERVICE SPECIFIC REVIEW FOR CPT CODE 66984, CATARACT SERVICES

The published results of that review showed that there were 425 claims reviewed, out of which 336 claims were denied. The denied dollar amount resulted in a charge denial rate of 82 percent.

The top denial reasons identified from that review were:

- 88 percent – 5D164/5H164 denial reason code, Documentation submitted does not support medical necessity
- 7 percent – 56900 denial reason code, No response in 30 days to an ADR
- 4 percent – 5D169/5H169 denial reason code, Services not documented
• LCD 30889-
• Cataract causing symptomatic impairment of vision not correctable by a change in glasses or contact lenses resulting in activity limitations
• A statement indicating that specific symptomatic impairment of visual function resulting in specific activity limitations.
• A statement or measurements indicating that the patient’s impairment of visual function is believed not to be correctable with a tolerable change in glasses or contact lenses.
• An appropriate preop ophthalmologic examination
• Ancillary testing as appropriate to establish medical necessity, such as Snellen testing, Glare testing
Conclusions

- Audits, both pre- and post-payment, are not going away and are now even targeting physicians
- We are all doing our best to interpret the confusing, contradictory and incomplete rules
- We are not criminals or committing fraud
- Auditors improperly use nurses and therapists to second guess complex physician judgment
  - See “Who audits the auditors?” on RACMonitor.com
Things To Do

• Help your doctors to document better
  ✔ If it’s not written, it wasn’t considered

• Be sure your medical records are complete
  ✔ Unsigned order = no order

• Review your processes for high cost/high risk procedures
  ✔ Compare documentation to LCD/NCD
  ✔ Review level of care

• Subscribe to your MAC’s newsfeed
Is there an upside to these audits?

- Proposed Rule CMS-1455-R
  - Hospitals with inpatient denials may rebill for full part B payment if within 1 year of date of service
  - Prepayment audits are more timely than RAC audits so plenty of time to review
    - Can appeal and fight for 364 days then withdraw appeal and file for part B
    - Can accept denial and file for part B right away

- Comment period March 18- May 17 so stand by for more details.
One final issue

• CERT and MAC auditors are not always right
• Per CERT Physician Specialist, disagree with admission as being reasonable and necessary. Procedures 45.73 (Open and other right hemicolectomy), 45.74 (Open and other resection of transverse colon) and 45.93 (Other small-to-large intestinal anastomosis) were medically necessary. The Beneficiary had anemia and transverse colon stricture with biopsy proven adenocarcinoma. CT was negative for metastasis. He underwent a right hemicolecotomy by laparoscopic approach. There were no postoperative complications and he was able to be discharged the next morning. This procedure can be safely done as outpatient, was scheduled electively and done without complications. There was no reason to admit as inpatient.

• But it’s on the inpatient only list!!!!!
THANK YOU FOR AttENDING