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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – As a health care provider subject to the privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or under State law, you must safeguard patients' personally identifiable health information. If you receive a remittance advice on a Medicare beneficiary who's not your patient, you should 1) destroy it and 2) report it to your fiscal intermediary, carrier, or Medicare Administrative Contractor, as appropriate.

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Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals

This is the second in a series of articles that will disseminate information on RAC Demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide inpatient hospital education regarding 17 RAC demonstration-identified medical necessity vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program and the initiation of complex medical necessity review in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider Types Affected

This article is for all Inpatient Hospital providers that submit fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

Provider Action Needed

Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

Background

The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper payment information from the RACs. However, it was on a voluntary basis, and was done at the claim level and focused on the collection. Some of these high risk medical necessity inpatient hospital vulnerabilities are listed in Table 1. These claims were denied because the demonstration RACs determined that the documentation submitted did not support that the services provided required an inpatient level of care and could have been performed in a less intensive setting.

Table 1.

	Provider Type	Improper Payment Amount (pre-appeal)	RAC Demonstration Findings
1	Inpatient Hospital	$64,739,662	Cardiac Defibrillator Implant (DRG 514/515)
2	Inpatient Hospital	$34,155,158	Heart Failure and Shock (DRG 127)
3	Inpatient Hospital	$21,956,139	Other Cardiac Pacemaker Implantation (DRG 116)
4	Inpatient Hospital	$19,169,815	Chest Pain (DRG 143)
5	Inpatient Hospital	$14,374,696	Misc. Digestive Disorders (DRG 182)
6	Inpatient Hospital	$13,881,479	Other Vascular Procedure (DRG 478)
7	Inpatient Hospital	$10,359,085	COPD (DRG 88)
8	Inpatient Hospital	$9,978,346	Medical Back Problems (DRG 243) -
9	Inpatient Hospital	$7,355,002	Nutritional & Misc. Metabolic Disorders (DRG 296)
10	Inpatient Hospital	$6,979,129	Transient Ischemia (DRG 524)
11	Inpatient Hospital	$6,228,919	Other Circulatory System Diagnoses (DRG 144)
12	Inpatient Hospital	$4,758,678	Kidney & UTI (DRG 320)
13	Inpatient Hospital	$3,239,751	Cardiac Arrhythmia (with CC DRG-138)
14	Inpatient Hospital	$2,912,155	Degenerative Nervous System Disorders (DRG 012)
15	Inpatient Hospital	$2,889,840	Atherosclerosis (with CC DRG-132)
16	Inpatient Hospital	$2,545,289	Other Digestive System Diagnosis (DRG 188)
17	Inpatient Hospital	$2,314,001	Percutaneous Cardiac Procedure (DRG 517)

Note: This listing describes what the RACs found the majority of the time when an improper payment was identified. Since each admission is unique, the root causes of each improper payment determination are also unique. *The collection figures identified do not take into account the results of appeals.* In addition to the list above, there are 3 other general categories of denials which included:

- Medical Necessity denials for multiple codes (not mentioned above);
- ASC List Violations for codes paid at the inpatient rate that should have been paid as outpatient (no complications identified to justify inpatient stay); and
- Other outpatient charges that should have been billed since services were not medically necessary in the inpatient setting.

These 3 catch-all categories of medical necessity denials impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.

Summary of RAC Demonstration Findings

The inpatient hospital vulnerabilities listed in Table 1 were denied because the services were not medically necessary for the setting billed. In many instances, the service/procedure was medically necessary but the services could have been performed in a less-intensive setting. Often, these denials occurred because the submitted medical documentation did not contain sufficient, accurate information to: 1) support the diagnosis, 2) justify the treatment/procedures, 3) document the course of care, 4) identify treatment/diagnostic test results, and 5) promote continuity of care among health care providers.

Inpatient Hospital Medical Documentation Reminders

CMS reminds providers that the medical record must contain sufficient documentation to demonstrate that the beneficiary's signs and/or symptoms were severe enough to warrant the need for inpatient medical care. See Chapter 6, Section 6.5.2 of Medicare's Program Integrity Manual at *http://www.cms.gov/manuals/downloads/pim83c06.pdf* for more detailed information.

CMS recommends that providers document any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or

health would be significantly and directly threatened if care was provided in a less intensive setting. (For more details see the manual chapter cited in the preceding paragraph.) Some factors that providers should consider when making the decision to admit may include:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital (see Chapter 1, Section 10 of the Medicare Benefit Policy Manual at *http://www.cms.gov/manuals/downloads/bp102c01.pdf* on the CMS website).

Documentation that is not legible has a direct affect on the RAC reviewer's ability to support that the services billed were medical necessary and were provided in an appropriate setting. CMS encourages providers to ensure that all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed, as appropriate. If a field is not applicable, CMS recommends that providers use an entry like "N/A" to show that the questions were reviewed and answered. Fields that are left blank often lead the reviewer to make an inaccurate determination.

CMS encourages providers to comply with CMS inpatient hospital policy and Coding Clinic guidance. In the absence of a specific Medicare policy, Medicare contractors may use clinical review judgment to assist in making a payment determination (See the Program Integrity Manual Chapter 3, Section 3.14 at *http://www.cms.gov/manuals/downloads/pim83c03.pdf* on the CMS website).

During the RAC demonstration, reviewers noted that entries in the medical records were not consistent. CMS encourages providers to ensure all entries are consistent with other parts of the medical record (assessments, treatment plans, and physician orders, nursing notes, medication and treatment records, etc. and other facility documents such as admission and discharge data, pharmacy records, etc.). If an entry is made that contradicts previous documentation, CMS recommends providers include documentation that explains why there is a contradiction.

Demonstration review staff often noted that providers failed to adequately document significant changes in the patient's condition or care issues that in some instances impacted the review determination. CMS recommends that providers document any changes in the patient's condition or care.

Lastly, CMS reminds providers to ensure that any information that affects the billed services and is acquired after physician documentation is complete must be added to the existing documentation in accordance with accepted standards for amending medical record documentation.

Additional Information

Providers are also encouraged to visit the CMS RAC website at *http://www.cms.gov/RAC* for updates on the National RAC Program. On that website, you can register to receive email updates and view current RAC activities nationwide.