



Get a Grip! Three Steps to Thwart RAC Success

By Donna D. Wilson, RHIA, CCS

Executive Summary

Grab tightly to the wheel, the Recovery Audit contractor (RAC) Permanent Program is underway! Automated Review denial letters for units of service started appearing on South Carolina providers' desks in August 2009. For a complete listing of the current automated review issues refer to:

http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx, or the RAC website for your region. Now that the Permanent Program has begun, providers should begin asking pertinent questions under each RAC area of focus.

This article will provide suggested questions to ask within your organization to ensure compliance with the Permanent Program. Using these questions as a baseline tool will also prepare providers for other governmental audits. The tools provided within this article will mainly address three areas of RAC focus. Remember this is not a comprehensive listing of RAC targets. The RAC initiative is a moving target and will continually change. Begin asking some of these questions, and assign departmental responsibilities so you too can drive safely throughout this RAC ride...

Introduction

Coming from a coding/health information management background, I felt as though all of my years of auditing inpatient and outpatient coding would prepare me for any governmental review. However, when the Recovery Audit Contractor (RAC) demonstration program moved into my home state of South Carolina, I found myself scurrying around to determine what areas would be targeted by this new auditor in town. Would the RACs focus on coding or medical necessity?

Networking with contacts in states that were earlier participants in the RAC demonstration program proved to be valuable for me in answering some of these questions. Also, the Centers for Medicare & Medicaid Services (CMS) website (<http://www.cms.hhs.gov/RAC/>) taught me the background and intent of the new governmental initiative.

Background

By now healthcare professionals have heard of the latest CMS initiative to detect and correct improper payments in the Medicare Fee for Service (FFS) Program. The RAC Program started as a 3-year demonstration in five states: California, Florida, New York, Massachusetts, and South Carolina. Because of the success of the demonstration program in returning dollars to the Medicare supported Section 302 of the Tax Relief and Health Care Act of 2006 (that makes the RAC program permanent) it now requires the Department of Health and Human Services (DHHS) Secretary to expand the program to all 50 states by no later than January 1, 2010. For complete details on the history of the demonstration program and the RAC expansion, visit the CMS website: <http://www.cms.hhs.gov/RAC/>.

I recommend you read the complete report of the demonstration program

which is titled *The Medicare Recovery Audit Contractors (RAC) Program: An Evaluation of the 3-Year Demonstration*. June 2008.

http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

RAC Readiness

Let's move into the steps to prepare for RAC audits. Learning from firsthand experience while working at a large acute care facility in South Carolina, allowed me to prepare for the RAC permanent program. In order for you to be prepared also, you will need to take into consideration some of the areas of key focus under the RAC demonstration program.

Read the complete report of the demonstration program.

Networking with other demonstration states allowed me to uncover the top three areas of their focus. The remainder of this article discusses those three areas: 1) medical necessity; 2) coding; and, 3) billing (units of service). As you follow the questions and the suggested responsible parties, consider the most effective ways to conduct auditing within your organization.

1) Medical Necessity—Our claims were denied under the demonstration program if they did not meet Medicare's medical necessity criteria for the service or setting.

A) Short stays on inpatient claims—RACs only used medical necessity screening criteria sets (such as Interqual and/or Milliman) as a guide in determining medical necessity. The RAC reviewer to determine medical necessity of the claim used clinical judgment.

1. Are you reviewing medical necessity for the following top RAC inpatient short stay denials?
 - a. Chest pain
 - b. Cardiac catheterizations
 - c. Cardiac defibrillators
 - d. Back Pain
 - e. Syncope

2. Have you developed and implemented a system-wide process for an initial physician order set? Patient status should be clearly marked in one of the three categories.

- a. Ambulatory/Outpatient
- b. Observation
- c. Inpatient (*see example 1 of an initial order set*).

3. Have you educated hospital staff and physicians on RAC findings and implemented process improvement methods to decrease future RAC medical necessity denials?

Responsible Department: Case Management and Physicians

B) Duplicate claims on outpatient services include services whereby the provider was paid twice for services rendered under the Medicare program. Two colonoscopies performed on the same day. If a distinct body and separate body system or approach was used in the colonoscopy, then applying a modifier -59 to the claim may be applicable.

1. Have you implemented computerized software edits to alert staff when duplicate codes are submitted on the same claim?
2. Are coders following outpatient coding modifier assignment guidelines (such as modifier -59)?

3. Have physicians been educated on proper documentation to support modifier -59?

Responsible Departments: Outpatient Coding and Physicians/Coders

Identify corrective action plans to promote compliance.

2) Coding/DRG Validations—DRG payment adjustments occurred on claims where the RAC found incorrect code assignments. Some of the coding errors identified under the RAC demonstration program included excisional debridement, lysis of adhesions, claims with one Complication or Comorbidity (CC) or one Major Complication or Comorbidity (MCC) and coagulopathy as a principal diagnosis.

A) Excisional Debridement (86.22) ICD-9-CM inpatient procedural coding was the leading ICD-9-CM procedural coding error. The RACs determined that the documentation in the health records did not meet the definition of excisional debridement. The procedure code did not meet the definition of excisional debridement.

Therefore consider the following when auditing excisional debridement cases:

1. Does the documentation in the health record reflect best practice by indicating the components involved in accurately documenting excisional debridement?
 - a. Size
 - b. Depth
 - c. Removal of devitalized tissue
 - d. Instruments used
 - e. Definite cutting away (not the minor removal or loose fragments)
2. Do the coders follow AHA Coding Clinic advice?
 - a. First Quarter 2008, Volume 25, page 3

- b. Fourth Quarter 2004, Volume 21, page 137
 - c. Second Quarter 2004, Volume 21
 - d. Second Quarter 2000, Volume 17, page 9
 - e. Third Quarter 1991, Volume 8
 - f. Fourth Quarter 1988, Volume 5
3. Have you educated physicians and coders on the proper documentation and coding regarding excisional debridement?

B) Lysis of adhesions (54.51 or 54.59) ICD-9-CM inpatient procedural coding was denied within the demonstration state of South Carolina. Coders should not code lysis of adhesions if it is used as an approach. The exception to this coding rule exists when the surgeon documents 'extensive' lysis of adhesions. The word *extensive*, in this context, may include obese patients or patients who have had previous abdominal surgery. The physician must clearly document the extent of the procedure in order to code lysis of adhesions in addition to the definitive surgery.

1. Does the operative note or progress note reflect an extensive lysis of adhesions? (i.e. Lysis of adhesions for over 20 minutes, multiple adhesions present in an obese male).
2. Do the coders follow AHA Coding Clinic advice?
 - a. Fourth Quarter 1996, pages 65–67
 - b. Third Quarter 1994, page 8
 - c. Fourth Quarter 1990, pages 18–19
3. Have you educated physicians and coders on the proper documentation and coding regarding lysis of adhesions?

C) One Complication or Comorbidity (CC) or one Major Complication or Comorbidity (MCC)—Inpatient coding guidelines indicate that coders must obtain confirmation of diagnoses from the attending physician for

Patient Status Order Sheet – Initial Order Set

Clearly indicate <u>ONLY ONE CHOICE</u> of Patient Status on arrival (CHECK ONE).
PATIENT STATUS MUST BE INDICATED PRIOR TO BED ASSIGNMENT.
XYZ Hospital Patients please fax order to Bed Management: 729-4000 ABC Hospital Patients please fax order to Bed Management: 403-1900
<input type="checkbox"/> Ambulatory/Outpatient <ul style="list-style-type: none"> ■ Includes procedure for which neither inpatient admission nor outpatient observation is expected. ■ Includes the typical/normal recovery period associated with procedure regardless of the time of the procedure. ■ Hospital stay pre-certified/pre-authorized for outpatient.
<input type="checkbox"/> Observation <ul style="list-style-type: none"> ■ Does not meet inpatient criteria. Contact Utilization Review: 729-2000 (XYZ Hospital) 403-1916 (ABC Hospital) with questions. ■ Alternative to inpatient admission when more time is needed to evaluate a patient's condition, response to treatment, and/or to determine the need for inpatient admission. ■ Patient has complications following an ambulatory/outpatient procedure.
<input type="checkbox"/> Admit Inpatient <ul style="list-style-type: none"> ■ Meets inpatient criteria. Contact Utilization Review: 729-2000 (XYZ Hospital) 403-1916 (ABC Hospital) with questions. ■ Procedure is listed on Medicare "inpatient only" listing (i.e.: Carotid endarterectomy, Cervical Fusion, Total Shoulder Replacement, Radical Neck dissection, Open Cholecystectomy). ■ Admission to critical care.
Physician Signature Date/Time:
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Nursing Signature Date/Time:

any diagnoses stated on pathology, radiology or laboratory reports.

1. Are diagnoses indicated on pathology, radiology or laboratory reports confirmed and documented by the attending physician in the health record?
2. Do the coders follow AHA Coding Clinic advice?
 - a. First Quarter 2004, pages 20-21.
 - b. Second Quarter 2002, pages 17-18.
 - c. Third Quarter 2008, Volume 25.
3. Is the attending physician queried/educated on proper documentation/coding assignments on inpatient health records?

D) Coagulopathy—Hemorrhagic disorder due to intrinsic circulating anticoagulants (286.5) ICD-9-CM.

Some coders within the demonstration states assigned principal diagnosis code incorrectly. Coders were interpreting that any patient on an anticoagulant could obtain the code assignment of 286.5 even if the patient did not experience a hemorrhagic disorder. The code 286.5 is assigned when an adverse condition has occurred—such as a bleed from the nose or gastrointestinal tract.

1. Are coders assigning 286.5 on all patients who are on anticoagulants (such as Coumadin)? Remember

Coumadin is not a circulating anticoagulant.

2. Do the coders follow AHA Coding Clinic advice?
 - a. Third Quarter 1990, volume 7
 - b. Fourth Quarter, 1993, Volume 10.
 - c. Third Quarter 2004, Volume 21.
3. Have coders been educated and audited to ensure proper code assignment of 286.5?
Responsible Departments: Inpatient Coding, Clinical Documentation and Physicians

3) Billing (Units of Service)—Our outpatient claims were denied under

the RAC demonstration program when an inaccurate number of 'units of service' appeared on a claim.

1. Neulasta (Pegfilgrastim) 6 mg (J2505). Provider billed one service per 1 mg; however, the HCPCS code definition indicates one service per 6 mg vial.
2. Speech/hearing therapy (92507). Provider billed one service for each 15 minutes; however the definition of this code is one service per session.
3. Blood transfusion service (36430). Provider billed one service per pint of blood; however, definition of this code is one service per transfusion session.
 - a. Are current HCPCS and CPT code books purchased and reviewed annually?
 - b. Is the chargemaster updated quarterly or at least annually to reflect any new code changes or definitions in code descriptions?
 - c. Is someone within the organization responsible for

reviewing and disseminating CMS transmittal information?

- d. Are ancillary departments educated on correct coding/charging?

Responsible Departments:
Pharmacy, Outpatient Rehab. Laboratory, Finance/Chargemaster and Outpatient Coding.

RAC Anticipation

As we all anxiously await the first wave of RAC reviews under the Permanent program, the fear of the unknown haunts providers. With the implementation of the 'new Issue review board' RACs may be reviewing an entirely different set of 'potential' improper payments. Therefore, in order to be prepared for the RACs, providers should see what improper payments were found by reviewing reports from other governmental agencies such as: OIG reports: www.oig.hhs.gov/reports.html and the CERT reports: www.cms.hhs.gov/cert.

If you identify improper payments as you 'Get a Grip', you can then proceed to identify corrective action plans to

promote compliance. Look for patterns in errors and continue to educate all applicable staff. Keep RAC education current at all departmental and administrative meetings. Appoint a RAC coordinator to facilitate and organize all RAC activity. Contact CMS with any RAC related questions at: RAC@cms.hhs.gov.

Summary

History can be a good teacher. Learning from the results of the RAC Demonstration Project, talking with those who have experienced a RAC audit then developing assessments and correcting identified issues in susceptible areas will help reduce the success of RAC audits of your organization. **NP**

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