Report on
MEDICARE COMPLIANCE
Volume 22, Number 5 • February 4, 2013

RAC Prepayment Reviews Move Forward as Their Targets Feel Heat from Other Audits

Recovery audit contractors (RACs) are slowly expanding their prepayment reviews to more MS-DRGs, including transient ischemia, which also face scrutiny in other audits.

CMS launched its prepayment demonstration on Aug. 27, 2012, with audits of syncope. RACs are instructed to validate the MS-DRG and evaluate the medical necessity of admissions *(RMC 11/5/12, p. 1)*. This quarter, RACs are edging into MS-DRGs for transient ischemia, gastrointestinal hemorrhage and diabetes, Alexandria, Va., consultant Carol Endahl said at a recent webinar sponsored by RACMonitor.com. Prepayment reviews focus on claims with historically high error rates, Endahl says, and MS-DRGs with stays of two days or fewer.

"They are approaching all facilities — PPS, PPS excluded and periodic interim payment [PIP] hospitals — and focusing on claims related to short stays," she said. RAC prepayment reviews will take place in 11 states: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania and Texas. But most RAC postpayment reviewers and some Medicare administrative contractors are barking up the same MS-DRG tree, she said. That means hospitals should be on the alert for claims denials. So far Connolly, the RAC for Region C, and HealthDataInsights, the RAC for Region D, have posted plans for prepayment reviews of transient ischemia (MS-DRG 069). Transient ischemic attacks (TIA) are "classically defined as a neurological deficit lasting less than 24 hours due to focal ischemia in the brain or retina," Endahl said. "What is critical here and why inpatient admissions occur most often for this diagnosis is it carries with it a very high risk of stroke. About 15% of diagnosed strokes are preceded by TIA."

From 200,000 to 500,000 TIAs are diagnosed every year in the United States, she said. The 2013 national payment rate for MS-DRG 069 is $3,984.29 and the average length of stay is 2.7 days. Last year, Medicare spent more than $351 million on 114,296 discharges for TIAs, and the average Medicare reimbursement per hospital last year for TIA was $104,067, Endahl said. She noted that 26.5% of discharges for transient ischemia were one-day stays last year, according to the TMF Health Quality Institute.

At least three MACs — Palmetto GBA (jurisdiction 1), Cahaba GBA (jurisdiction 10) and Novitas Solutions (jurisdiction 12) — have prepayment reviews of transient ischemia MS-DRGs under way, and they are finding high error rates, Endahl notes. Problems include documentation that doesn't support the medical necessity of the admission; the hospital's failure to respond to the MAC's additional documentation request; documentation submitted that doesn't match the dates billed; no physician order; admissions that weren't warranted based on the patient's severity of signs and symptoms or intensity of services; documentation that did not support the medical predictability of an adverse outcome; and/or documentation that was missing or insufficient.

"Although this condition carries a high risk of stroke occurring, it has to be documented that the physician has done the work required to make this determination," Endahl says. The National Stroke Association and American Stroke Association have published guidelines that will help establish when patients are eligible for admission. Also, there is an "ABCD" risk assessment for determining the chances of stroke after TIA. "A" stands for age, "B" for blood pressure, "C" for clinical features (i.e., unilateral weakness with or without speech disturbance), and "D" for duration and for diabetes. "Physicians go through each of these factors and assign points to determine who is at risk for stroke, and if all of this is documented in the medical record, admission won't be questioned," she said.

Gastrointestinal hemorrhage also is a frequent cause of admission and has an audit target on its back. The three MS-DRGs in the RAC prepayment review are GI hemorrhage with complications and comorbidities (MS-DRG 378), GI hemorrhage with major CC (MS-DRG 377) and GI hemorrhage without CC/MCC (MS-DRG 379).

Total Medicare spending on MS-DRG 377, for example, was about $763.9 million in 2012. The number of discharges was 88,901 and average reimbursement per hospital was $226,408. In 2013, the national payment rate is $9,529.88 and the average length of stay is 6.3 days, Endahl says. The three MS-DRGs for GI hemorrhage are in the top 20 Part A inpatient service types with the highest improper payments, according to CMS's most recent Medicare fee-for-service error report *(RMC 9/3/12, p. 1)*.To

help confirm the medical necessity of admissions, Endahl said documentation should specify the location of the ulcer or other lesion, whether it is acute or chronic and whether there is acute blood loss anemia.

Another area of RAC and MAC scrutiny is diabetes with MCC (MS-DRG 637), diabetes with CC (MS-DRG 638) and diabetes without CC/MCC (MS-DRG 639). Medicare spent about $233.7 million on MS-DRG 638 last year, for example. The total number of discharges was 57,852 and the average Medicare reimbursement per hospital was $69,280, Endahl said. The national payment rate for 2013 is $4,395.61 and the average length of stay is 3.8 days.

A recent review of MS-DRG 639 by the comprehensive error rate testing (CERT) contractor of claims submitted to Trailblazer Health Enterprises found medically unnecessary services and inpatient admissions for diabetes patients who could have been safely treated in observation, she noted.

Documentation should specify whether patients have Type I vs. Type II and controlled vs. uncontrolled as well as high and low blood glucose readings and insulin units that patients received above routine daily doses, she said.

Medicare reviews continue to raise the stakes for admission decisions. Generally, they come down to this: "Those patients that physicians have high levels of concern for highly predictable events tend to be inpatient. Those patients that physicians have low levels of concern for tend to be observation," says John Zelem, M.D., executive medical director of education and client relations for Executive Health Resources in Newtown Square, Pa. "These are generalizations but will very much help in making the decision on how to take what they know clinically and transition it into a level of care."

The Medicare Benefit Policy Manual states that physicians must take into account complex factors when determining whether an admission is medically necessary. They include severity of signs and symptoms, availability and the presence of diagnostic studies and the medical predictability of an adverse event occurring. However, Zelem says it's hard to predict when things may go wrong. "One must remember that the retrospective reviews are performed by nurses and therapists and not physicians. Yet they are making determinations on physician judgment," he says. "However, clear documentation of the physician's intent and evaluation of the patient is a critical component to ensuring compliance with rules governing the medical necessity of a hospital admission."

Guidelines Help MDs With Documentation

Here are Zelem's "4½ guidelines" to help physicians improve documentation:

Suspects: "Physicians generally will get an idea of what they suspect is going on based on the conversation that they have with the patient. Commonly this is referred to as a differential diagnosis," Zelem says.

Concerns: "Physicians will then risk-stratify their patients and develop some concerns for what is going on," he says. That means either low levels or high levels of concern for what can go wrong with the patient.

Predictable risks: "Physicians know and understand the risks that their patients are at based on their knowledge of the literature, their clinical practice, their experience and their education," he notes.

Intent: "What is their intent for treatment and what is their intent for an overnight stay?"

The ½ is the use of the word "because," which Zelem says is a great transition word. "I am admitting this patient because…. I am ordering this test because….It helps put some final conclusions together and gives information to help with documentation."

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Results of Medicare Compliance Review: Baton Rouge General Medical Center

Risk Area	Sampled Claims	Value Of Sampled Claims	Claims With Overpayments	Value Of Overpayments
Inpatient short stays	56	$404,381	33	$227,358
Inpatient claims paid in excess of charges	28	679,749	6	107,615
Inpatient same-day discharges and readmissions	13	291,041	5	25,627
Inpatient claims billed with high-severity-level diagnosis-related group codes	26	407,360	0	0
Inpatient hospital-acquired conditions and present-on-admission indicators	24	2,114,901	0	0
Inpatient manufacturer credits for replaced medical devices	5	50,440	0	0
Inpatient Total	**152**	**$3,947,872**	**44**	**$360,600**
Outpatient claims with payments greater than $25,000	4	$177,419	1	$10,666
Outpatient claims billed with modifier -59	17	10,079	3	1,647
Outpatient Total	**21**	**$187,498**	**4**	**$12,313**
Inpatient and Outpatient Total	**173**	**$4,135,369**	**48**	**$372,913**

SOURCE: HHS Office of Inspector General