

MEDICAL NECESSITY~RAC PROOFING YOUR DOCUMENTATION

Here We Go Again?

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MGMA: The Patient Financial Services
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Medicare Claim Volume

Medicare receives over 1.2 BILLION claims per year*

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute

As much as 3.6% are thought to be incorrect!

Definition of “Medically Necessary”

Social Security Act §1862(a)(1)(A). This section of the act states no Medicare payment shall be made for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

How is Reasonable and Necessary Determined?

- Contrary to belief, this is not determined by the insurance companies.
- The Physician still has the power, BUT--
--the medical record must reflect how this decision is made. Example-patient has JVD and the doctor feels the patient is experiencing right-sided heart failure. Make note of findings and plan of care.

CRITERIA = Case Managers=CMS=RAC=BIG BROTHER?!

- Interqual/Milliman
- Inpatient status
- Observation status
- Inpatient to Observation = changing status
- Observation to Inpatient = changing status
- And the rules change every year!

A Few Simple Rules

- Case manager is not to be viewed as the enemy.
- The physician advisor is not to be viewed as the enemy.
- This is far less complicated than going to medical school.

Severity of Illness/Intensity of Service

- How sick is your patient?



- What are you doing for this sick patient?

Project Culprit Find

- Denial project started to get to the root cause.
- Imagine the ED found to be the biggest offenders of incorrect status!
- Presented data to the Director of the ED- Doctor who also happens to be an attorney as well!!!



Presentation of Individual Cases

- Chest pain with negative enzymes, unchanged ECG, history of AMI with stent placement (date unknown by records), pain resolved and hemodynamic stability (systolic BP>100). Orders written for continuous cardiac monitoring, serial enzymes, PO meds
- CLEARLY meets observation (ADLT-6) -- after all the BOOK says so!!
- Doctor/lawyer replies-Are you telling me a patient who had a stent placed, wherein, post procedure he became hypotensive, had to return to the cath lab, should not be admitted to ICU? No doctor in their right mind would send this patient home. **WOULD THEY?**

WHAT IS IN THE PHYSICIAN'S HEAD IS NOT IN THE AUDITORS!

- Of note, new criteria changes to take co-morbid conditions into account.
- Records must support the physician's decision to admit.
- Auditors will NOT spend the time looking for the Physician's thought process. They will deny and let the hospital spend money and resources on appeals.

Appeals Statistics

- Number of claims with overpayment determinations
525,133
- Number of claims where provider appealed (any level)
118,051
- Number of claims with favorable provider decisions
40,115
- Percentage of appealed claims with provider favorable outcomes
34.0%
- Percentage of claims overturned on appeal
7.6%

Examples of Really Poor Documentation

- From „history“ section of an EEG report-“this is a 67-year-old female with questionable jerks”
- From attending“s note on rounds- “Still not too peppy; needs to poop”
- From ED admission note: “the patient was not feeling well for a couple of days and she went to work and hit on trees.”
- From a student nurse-“pt. appears lucid @ times, but becomes lucid when verbally stimulated.”

And My Favorites

- From nursing notes- “pt. flipping nurse off while talking to family.”
- From nursing notes- “Small decub @ crack of hyne; butt paste applied.”
- From nursing notes- “pt. found lighting cigarette-instructed to distinguish cigarette.”
- From nursing notes- “went to card cath lab in bed with RN”

CONSEQUENCES

- DENIALS!!
- Lack of documentation increases the use of GZ modifier by coders (article I read stated an edit is picking this up?!!). GZ modifier is applied when documentation does not meet Medicare policy standards for medical necessity and an ABN was not obtained. GZ modifier claims trigger non-payment by Medicare.
- The real concern is patient safety issues and revenue out the window!!

What is Best Practice?

- Legible, complete, dated, timed, authenticated
- Medical history & exam (H&P)
- Nursing & medication notes, etc.
- Diagnosis = Impression
- Plan of Care
- Orders – signed, dated, timed
- Evaluation results & review
- All events
- Discharge Summary
- Final Diagnosis
- Avoid the word admit when patient is in an OP status

Benefits of Improving Documentation

- Patient safety increases!
- Proper status determination = decreased denials.
- RAC auditors will have a lot less work in your facility.
- Cases are defensible on audit.
- Coders are able to capture CC"s (complications & co morbidities) and MCC"s (major complications and co morbidities), increasing CMI.
- Case managers are better equipped to develop a discharge plan, which leads to decrease in length of stay.

What Can FINANCE Do to Help?

Support Care Coordination Department at budget time. Find “other” areas to make cuts.

- Enough staff to teach physicians
- Care Management tools
- Strong Physician Advisor program

Other Accreditation & Regulatory Considerations

- RAC Demonstration Program yields high dollar returns & Permanent Program approved
- Consolidation of Medicare Part A & Part B into MACs
- Office of Inspector General audits
- States implement Office of Medicaid Inspector General
- Medicaid Integrity Contractors initiated
- Present on Admission Indicators and Hospital Acquired Conditions in place nationally

Other Accreditation & Regulatory Considerations

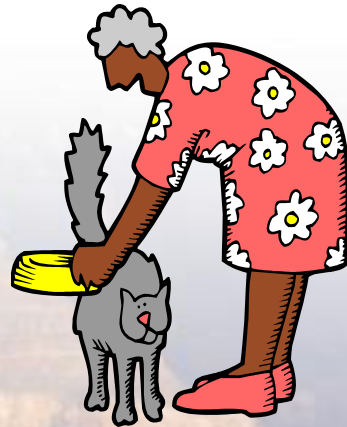
- The Joint Commission (TJC) accreditation alignment CMS Program Integrity with CoPs
- CoP Tag A-0652, 42 CFR 482.30
- TJC LD.04.01.01 EPs 17 and 18 (effective 1/1/2011)
- UR Plan required and includes all required elements of CoPs
- Admission and continued stay reviews

Other Accreditation & Regulatory Considerations

- Compliance with the CoPs leads to TJC or DNV Healthcare continuous compliance
- CMS is prescriptive and detailed
- Medicare survey is compliance driven
- If in doubt, use the most prescriptive; State vs. CMS vs. Accrediting agency
- Must always be compliant

If You Want RAC to Go Away

STOP FEEDING THEM!!!



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