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

News Flash – The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have end-stage renal disease (ESRD). CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility' s payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system. For additional information please see the CMS Fact sheet (7/26) at *http://www.cms.gov/apps/media/fact_sheets.asp* on the CMS website.

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Recovery Audit Contractor (RAC) Demonstration High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals

This is the third 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 four RAC demonstration-identified inpatient hospital coding 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 coding 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

Effective March 2005, the RAC Demonstration began in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008. 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 hospital payment information from the RACs. However, it was on a voluntary basis, at the claim level and focused on the collection and not the principal and secondary diagnoses on a claim. Four of the high risk inpatient hospital coding vulnerabilities identified are listed in Table 1 below. These claims were denied because the demonstration RACs determined that the medical record documentation submitted did not support the codes billed.

Table 1.

	Provider Type	Improper Payment Amount (pre-appeal)	RAC Demonstration Findings
1	Inpatient Hospital	$15,999,757	Respiratory System Diagnosis with Vent support – (CMS DRG 475) – Principal diagnosis on the claim did not match the principal diagnosis in the medical record.
2	Inpatient Hospital	$11,769,645	Closed Biopsy of Lung (CMS DRG 076, 077,120) - A transbronchial lung biopsy was billed but the medical record showed a transbronchial biopsy was performed.
3	Inpatient Hospital	$10,014,530	OR Procedure for Infections, Parasitic Diseases (CMS DRG 415) – The codes on the claim did not match information in the medical record.
4	Inpatient Hospital	$2,127,568	Coagulopathy (CMS DRG 397/143) - Principal diagnosis on the claim did not match the principal diagnosis in the medical record.

Note: *The collection figures identified do not take into account the results of appeals.*

For example, one of the coding vulnerabilities the RACs identified was that hospitals were inappropriately reporting a surgical code 33.27, Closed endoscopic biopsy of the lung. The medical record documentation indicated that the site of the biopsy was the bronchus, not the lung, and therefore the correct code to bill is the non-surgical code 33.24, Closed endoscopic biopsy of the bronchus.

Inpatient Hospital Medical Documentation Reminders

CMS reminds inpatient hospital providers that all inpatient admissions must have the principal diagnosis specifically identified by the attending physician. The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care. CMS recommends that the principal diagnosis be documented in the medical record and on the discharge summary. CMS Official ICD-9-CM Coding Guidelines can be found at *http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm* on the Internet.

All inpatient admissions must have all "other" or "secondary" diagnoses identified by the attending physician. "Other or "secondary" diagnoses are additional conditions that affect patient care. The general rules for reporting secondary diagnoses are:

1. Must be documented by the attending physician and:
2. Clinically evaluated or
3. Diagnostically tested or
4. Therapeutically treated or
5. Causes an increase in the length of stay (LOS) or nursing care (Federal Register, July 31, 1985, volume 50, No., 147, pp. 31038-40).

For Non-surgical DRGs, CMS recommends that providers ensure "secondary" or "other" diagnoses which are documented in the medical record and on the discharge summary. CMS also recommends listing all procedures performed during the admission on the discharge summary or assuring all procedures are easily identified in the medical record documentation.

CMS encourages providers to ensure that all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed. If a field is not applicable, CMS recommends that providers use an entry such as "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).

Documentation that is not legible has a direct effect on the RAC reviewer's ability to support that the services billed were coded correctly, medically necessary and were provided in an appropriate setting.

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 documentation found elsewhere in the record, CMS recommends providers include documentation that explains why there is a contradiction.

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.