RECOVERY AUDIT CONTRACTORS

RAC SUBSCRIPTION SERVICE
"What Are We Learning?"

February 22, 2011

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RAC Subscription Service: Webinar Overview

- "RACs: Being Proactive"
  - Second Tuesday of each month
  - Discuss one or two high-risk areas for RAC review
  - Review ideas on how to proactively audit
  - Propose operational safeguards

- "RACs: What are We Learning"
  - Fourth Tuesday of each month
  - Keep subscribers up-to-date on RAC developments
    - Discuss RAC updates
    - Analyze publicly available decisions involving RACs
  - Pool questions from subscribers

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RAC Subscription Service: Webinar Overview

- Regularly scheduled Webinars will be supplemented, as necessary, with special “emergency” sessions

- Administrative Matters
  - Each session will be 60-75 minutes in duration, including a question and answer session
  - Each session will begin at 12:00 PM CT
  - If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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Goals

- The goals of the RAC Webinars:
  - Teaching/knowledge transfer
  - Practical points
  - Assist organizations to develop in-house methods of managing
  - Please share your thoughts, suggestions (and criticisms)

- Our Perspective—
  - *Defend your claims*: Appeals process is critical
  - *Manage your compliance risks*: Compliance implications to a RAC review must be addressed – the RAC process is not just about RAC recovery
  - *Be proactive*…and preemptive

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Today's Topics and Agenda

- DCS Overturns Automated Review of Untimed Codes
- Medicaid Program – Proposed Rule – Provider Preventable Conditions
- EMTALA Advanced Notice of Proposed Rulemaking

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Untimed Codes and NCCA - OPPS

- On February 16, 2011, DCS (RAC Region A) announced that it was “overturning two automated reviews in RAC Region A.”
  - Untimed Codes (A000152009)
  - NCCI – OPPS (A000112009)

- Untimed codes was also an approved issue in the other RAC regions. NCCI – OPPS was approved only in Region A

- Previously recouped monies would be repaid

- No further explanation provided

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Untimed Codes

Issue Name:	Untimed Codes
Issue Number:	A000152009
Issue Description:	A potential vulnerability may exist if certain codes are billed for more than one unit. Therefore, an issue may exist when these codes are billed and are reimbursed under Medicare Part B in this manner.
Type of Review:	Automated Review for Overpayments
State(s) Affected:	CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT
Providers Affected:	Physician (Carrier) / Outpatient Hospital
Date Posted:	June 17, 2010
Dates of Service:	October 1, 2007 - Present
Issue References:	IOM 100-04, Chapter 5, Section 20.2; IOM 100-04, Transmittal 1019, dated 8.3.06, pages 7-11

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Untimed Codes

- Outpatient rehabilitation/therapy issue
- For procedures not defined by a specific timeframe (e.g., SLP evaluation)
- What was DCS's error?

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NASL Website

- "As we reported earlier this month, NASL and AHCA had received word that providers in RAC Region A were receiving demand letters from Diversified Collection Services (DCS), the Region A RAC contractor, on the CMS-approved issue of untimed codes. However, in response to a strong protest from AHCA and NASL, DCS has confirmed that the letters were based on an incorrect interpretation of the untimed coding issue. DCS has informed AHCA and NASL that it will be sending letters to affected providers rescinding the previous demand letters."

- "Following is the response we (NASL) received from DCS:

  DCS has discovered that the New Issue A000152009 for Untimed Codes was incorrectly interpreted to allow only one unit "per the entire code set" (90901, 92506, 92507, 92508, 92526, 92597, 92605, 92606, 92609, 92610, 92611, 92612, 92614, 92616, 95833, 95834, 96110, 97001, 97002, 97003, 97004, 97010, 97022, 97026, 97597, 97598).

  Instead, this New Issue should have been interpreted as allowing only one unit "per each individual code" per date, per member."

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NASL Website

- *It appears that DCS made a recommendation to deny/recoup based on the presence of multiple untimed procedure codes billed on the same claim. Examples show that none of the untimed codes had more than one unit of service billed, per member, per date of service. A recommendation should have been made only when more than one unit of service, per procedure code, was billed.*

  We apologize for this error and will be sending rescind letters in the next week to providers who were audited for this issue.

- NASL appreciates the leadership of AHCA in pressing for a quick resolution to this problem. Our organizations have pledged to continue working jointly in addressing future RAC issues.

- We encourage providers to remain vigilant and report to NASL and AHCA any RAC issues that do not appear to apply to skilled nursing facility therapy services, or that appear to be incorrect interpretations of relevant manual provisions and guidance. We are working with CMS to ensure that CMS-approved RAC issues are applied to the right provider group, and are interpreted and applied in an appropriate manner.

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National Correct Coding Initiative (CCI) - OPPS

Issue Name:	National Correct Coding Initiative (CCI) - OPPS
Issue Number:	A000112009
Issue Description:	Application of the OPPS National Correct Coding Initiative (Mutually Exclusive and Non-Mutually Exclusive). Deny Column II code when billed by the same provider and same date of service as a Column I code.
Type of Review:	Automated Review for Overpayments
State(s) Affected:	CT, DC, DE, NJ, NY, PA
Providers Affected:	Outpatient Hospitals
Date Posted:	September 28, 2010
Dates of Service:	October 1, 2007 - Present
Issue References:	

Internet Only Manual 100-04 Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Subsection 20.9 (Correct Coding Initiative), revision effective 10/1/2003; Column I/Column II code pairs are date sensitive. 2) Integrated Outpatient Code Editor Software, versions 8.3 (effective 10/1/2007) and higher, edit #s 19, 20, 39, and 40.; NCCI Edits - Hospital Outpatient PPS; Outpatient Code Editor - Overview;

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CCI

- Promote national correct coding methodologies and to control improper coding to inappropriate payment in Part B claims

- CCI edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against NCCI tables

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CCI Edits

- There are two types of edits arranged by two sets of tables:
  - Column I/Column II Correct Coding Edits (formerly Comprehensive/Component) – identifies code pairs that should not be billed together because one service is an integral part of the other or should not be reported together for other reasons (e.g., “misuse of the code,” etc.).
  - Mutually exclusive edits – identifies code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

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Medicaid Program—Proposed Rule

- On February 17, 2009, HHS published a proposed rule that would prohibit federal payments to states for amounts expended for providing medical assistance for health care acquired conditions (HACs)

- Proposed rule would also authorize states to identify other provider-preventable conditions for which Medicaid payments would be prohibited

- Implements Section 2702 of the ACA of 2010

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HACs and Medicare

- On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (Pub. L. No. 109-171)
- Section 501(c) of the DRA amended Section 1886(d)(4) of the Social Security Act (42 USC 1395ww(d)(4)) by adding a new subparagraph
- That subparagraph required the following:
  - Selection of HACs: Not later than October 1, 2007, the Secretary of HHS was to identify diagnosis codes associated with at least 2 conditions that satisfied the following requirements:
    - High cost, high volume or both
    - The code results in a DRG that has a higher payment when present as a secondary diagnosis
    - The condition could reasonably have been prevented through the application of evidence-based guidelines
  - Payment Adjustment: Commencing with discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payments for the secondary diagnoses associated with the selected HACs
  - POA Indicator: To facilitate implementation of the payment adjustment for the selected HACs, for discharges occurring on or after October 1, 2007, information required to be reported by an IPPS hospital for inpatient discharges is to include secondary diagnosis at admission (the POA Indicator)

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Medicare HACs

- Foreign Object Retained after Surgery
- Air Embolism
- Blood Incompatibility
- Catheter-Associated UTIs
- Vascular Catheter Associated Infections
- Pressure Ulcers (Stages III and IV)
- Falls (complications from)
  - Fractures
  - Dislocations
  - Intracranial injury
  - Crushing injury
  - Burns
  - Electric Shock
- Surgical Site Infection, Mediastinitis following CABG
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Surgical Site Infection following Certain Orthopedic Procedures
- Surgical Site Infection following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism following Certain Orthopedic Procedures

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Medicaid HACs

- DRA applied only to Medicare, however CMS previously issued guidance to states to encourage adoption of prohibition on payments for HACs
- ACA required HHS to implement payment adjustments for provider preventable conditions (PPCs) effective July 1, 2011
- Provider self-reporting obligation

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EMTALA Advanced Notice of Proposed Rulemaking

- Issued December 23, 2010
  - 75 Federal Register 80,762
- Comment period closes February 22, 2011
- What does this mean?
  - CMS believes EMTALA regulations need reviewing, specifically with respect to inpatients, in light of recent court cases
  - Soliciting comments on whether it would be beneficial to revisit the regulations

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EMTALA Update

- What is causing CMS to revisit the regulations?
  - The question whether EMTALA obligations extend to inpatients
  - Federal courts have been divided as to whether EMTALA obligations extend to inpatients or whether it is only an outpatient law

- Basic obligations (very abbreviated!):
  - Hospitals must provide a *medical screening examination* to patients who present to the hospital requesting an examination
  - The medical screening examination must determine whether the patient has an *emergency medical condition*
  - If the patient has an emergency medical condition, then the hospital is obligated to provide care to *stabilize* the patient without respect to the cost of the care
  - Various rules govern when and how the hospital can *transfer* a patient who is not stable and whether the receiving hospital must accept the patient

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The Regulations

- §489.24(d) Necessary Stabilizing Treatment for Emergency Medical Conditions

  - (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either–

    - (i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.
    - (ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

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EMTALA Update

- Courts are divided over when the obligation to provide care through stabilization ends
  - Some courts have considered that there is no time limit on the hospital's obligation and that this can extend through admission and to inpatient. In other words, if the patient is not stable after admission, then EMTALA obligations continue
  - Other courts have considered that EMTALA's obligations end at admission and patients who are inpatients and become unstable, then EMTALA obligations arise
  - The statute is unclear

- CMS has issued the notice in order to solicit comment and presumably to take a more forceful position one way or another

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EMTALA Update

- CMS's current position is set out in the State Operations Manual – Appendix V "Interpretative Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency"

- "A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

  – That no emergency medical condition exists (even though the underlying medical condition may persist);

  – That an emergency medical condition exists and the individual is appropriately transferred to another facility; or

  – That an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment."

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§489.24(d)(2) Exception: Application to inpatients.

(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

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Take-away and what might happen

- It is not known yet what position CMS will take:
  - Will it continue with its existing regulations and interpretative guidelines?
  - Will it revise its guidelines and extend EMTALA to all inpatients?
- Watch over the next few months what will happen.
- Forecast: If CMS is going to stick with its current regulations and defend them in the face of court cases ruling differently, why would CMS begin the solicitation of comments process?

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Follow-Up

- Questions?

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- Next Lecture:

Tuesday, March 8, 2011

12pm CT/1pm ET

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