First IL HFMA Fall Summit

Using Retrospective Review to Reduce Medicare Billing Errors
Your Presenters

Kathi Austin, CPC, CPC-H, CCP
Executive Director, MRM Revenue Integrity
Mercy

Candice Daszewski
Account Manager
Vaughan Holland Consulting, Inc.

Tanya Hawkins
Director of Operations
Vaughan Holland Consulting, Inc.
Objectives

• Illustrate obstacles contributing to billing errors
• Review traditional revenue cycle programs and processes
• Understand how errors continue to occur and why retrospective review brings them to light
• Learn how to conduct a retrospective review
  – Understand existing Medicare regulations
  – Create compliant processes and policies
  – Learn the risks associated specific areas of revenue cycle
  – Review in detail the following areas:
    • Post Acute Transfers
    • Pharmacy charges
    • Coding
• Understand the “Clerical Reopening” regulations
• Begin Your Own Retrospective Review
• Participate in a live Case Study: Mercy Hospitals
Looking for a Miracle

Good work Antworth, but I think we might need just a little more detail right here.
Obstacles
Distractions

• Staff turnover
  – System Maintenance
  – Contract/Temporary Labor

• Over extending internal resources
  – System implementations
  – Process redesign for impacting regulations
  – Non-productive time for training and education
I’m looking for help on this, virtual team...

Traditional silos getting in the way?

Function: It’s not in my P & L.

Country: It’s not in my objectives.

Product Group: I’d like to help, but...
We have this covered...right?

• Charge Capture
• Charge Description Master (CDM)
• Billing Edits
• Coding Audits
• Managed Care Reviews
• Internal Teams – Over/Under Payments
• Denials Management
Your Insurance Policy

• Identify Revenue Cycle Improvements
• Adjust systems and processes
• Provide training
• Recapture lost revenue
• Get piece of mind
Retrospective Review Objectives

- Medicare Administrative Contractor (MAC)
- Zone 3 ZPIC
- RAC Auditor
Post Acute Transfer Policy (PACT)

PACT rules are found in the Code of Federal Regulations (CFR) at 42 CFR Section 412.4.

The Code of Federal Regulations (CFR) at 42 CFR Sections 405.980 (b) and (c), and Section 405.986, states that a Medicare contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists. If a contractor performs data analysis on claims and finds potential claims errors, that may constitute new and material evidence, as it relates to good cause for reopening the claims. Justification for reopening these claims was due to improper payments found in the results of the data analysis.

When Medicare reopens such claims and the resulting analysis shows an error occurred, Medicare will adjust the initial claim accordingly. To avoid this situation, providers should strive to ensure accuracy in submitting inpatient claims with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).
Medlearn Matters

• 42 CFR 412.4 – Discharges and Transfers
• MM3240 – Concerns for changing patient status codes
  – Refer to Change Request (CR) 3240
• SE0801 – Clarification of Patient Status Codes
• SE1335 – Post-Acute Transfer Processing of CWF A/B Crossover Edit
Compliance Review - SNF

03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care. This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an approved swing bed arrangement, use Code 61- Swing Bed. This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64.

Code 03 should not be used if:

• The patient is admitted to a non-Medicare certified area.
Risk - SNF

• 3 day qualifying stay
• Exhausted Benefits
• Skilled or intermediate care
• Medicare Certified Bed
Compliance - HHA

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care

This code should be reported when a patient is:

- Discharged/transfered to home with a written plan of care for home care services (tailored to the patient’s medical needs) – whether home attendant, nursing aides, certified attendants, etc.
- Discharged/transfered to a foster care facility with home care; and
- Discharged to home under a home health agency with DME.

This code should **not** be used for home health services provided by a:

- DME supplier or

A) **Code 06** would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:

- **Condition Code 42** – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;
- **Condition Code 43** – Continuing care not provided within prescribed post-
Risk - HHA

• Actual patient care LIDOS
• Billing correct condition code
• Clinical reviews for related care
• Care outside 3 day window
• Claims submitted outside timely filing
• Non-compliant patients
Hi Tanya,
I wanted to update you that we have made some changes to our edits that will look at the LIDOS on the HH claim instead of the episode start date. Please look for a Special Edition MLN article in the near future that addresses this.

Thanks!

Sarah Shirey-Losso
Division of Institutional Claims Processing/Hospital Team Lead
Provider Billing Group/Center for Medicare/CMS
(410) 786-0187
Email: sarah.shirey-losso@cms.hhs.gov

Good Afternoon Sarah,

Have you all survived the IP FR rules? Is there any chance your group has looked at my questions?

Have a great weekend!

Tanya
Changes to CWF Edit 7272

• New Medlearn Article – SE1335

CMS recently reexamined the post-acute transfer processing in the Common Working File (CWF) system of an Inpatient Prospective Payment System (IPPS) hospital claim when a home health claim is present in claims history, and discovered a change was necessary. CWF A/B Crossover Edit 7272 for transfers to home for home health services is using the home health *episode* start date instead of the first home health *line item date of service (LIDOS)* date following an IPPS hospital discharge to determine if a post-acute transfer exists. This edit has been modified to correct CWF A/B Crossover Edit 7272 to ensure that the system is following the transfer processing rules. Providers need to be aware of this change.

If you believe that your claim(s) was incorrectly processed, please contact your Medicare FI or MAC for resolution.
"Another question concerns what coders and billers should do when home healthcare is unrelated to the reason for the inpatient stay. For example, if a patient with a urinary tract infection (UTI) is discharged to home healthcare for resumption of care for a decubitus ulcer (and not the UTI), coders and billers can report condition code 42, says Haik. This condition code indicates the home health treatment plan is unrelated to any conditions or services addressed during the inpatient stay. Conditions treated during the hospital stay include those for which a patient was admitted, as well as any new conditions that developed during the stay, says Haik.

Many hospitals don’t report condition codes 42 and 43, says Mackaman. Instead, they simply assign discharge disposition code 01 (discharge to home) when patients don’t meet the criteria for 06. This practice is noncompliant and could subject hospitals to Office of Inspector General reviews and RAC audits, she says."

However, the CWF makes it extremely easy for RACs to review a high volume of claims very quickly and efficiently, says Mandy Thompson, CPC, a coding and compliance consultant at Kraft Healthcare Consulting. “It’s easy for them to mine the data for errors. It shows when patients start and stop receiving services, and it also shows when patients move from one level of care to another,” she says.....

The patient may use Medicare Part B, another type of insurance, or self-pay for the services; however, no Medicare Part A bill is generated because it won’t pay for noncovered skilled care, says Haik. This means it appears in the CWF as though the patient never received the care at all.

Although skilled nursing facilities are required to submit no-pay claims that would show up in the CWF, many facilities do not comply. As a result, RACs are basing their decisions on information that’s not entirely accurate, Haik says. ‘Even though [the patient] didn’t have covered skilled care, he or she was still a Medicare patient who got skilled care in a Medicare-certified facility,” he notes.
MR Addendums

• Create or request the MR addendum
• Contents documented
  – Reviewer
  – PACT facility and contact
  – Patient information received
    • Clinical (485) or
    • Other
Revenue Cycle Improvements

• Post Acute Transfer Reviews
  – Communication post discharge
    • Prevent readmissions
    • Determine if stay is related?
    • Identify your non-compliant patients
    • Improved patient satisfaction
  – Improve documentation in the medical record
    • Update coding to reflect actual course of treatment, not ordered
    • Ensure your documenting the name of transfer facility
The OIG Compliance Program Guidance for Hospitals states that "an ongoing evaluation process is critical to a successful [coding] compliance program." It suggests that "Monitoring and Auditing," as well as, "Response to Detected Deficiencies" is the best way to establish a firm compliance program. CMS's Medicare Integrity Program expects that facilities will include accurate, thorough, competent, and effective auditing and monitoring of coding & billing processes as part of their overall compliance program.
Risk – Coding

• Coding with incomplete medical records
• Reliance on the encoder
  – Not asking other questions
  – Additional units or procedures
• Billing – work queues
  – Removing Codes
  – Bundling codes
• Education opportunities
• Validate education retained
Coding Reviews

• Missing codes (Insertion/Removal)
  – Add 57267 – Insertion of Mesh Procedure
  – Add 33249 - Eltrd/insert pace-defib
  – Add 57282 - Colpopexy, extraperitoneal
  – Add 36870 - Percut thrombect av fistula
  – Add 19125 - Excision, breast lesion

• Specificity
  – Replace 19499 Breast surgery procedure with 19297 Place breast cath for rad
  – Replace 53899 Urology surgery procedure with 53500 Urethrlys, transvag w/ scope
  – Replace 37186 Sec art m-thrombect add-on with 36870 for Mechanical thrombectomy of AV graft procedure. Also add 35476 for angioplasty.

• Modifier 59 Separately payable
  – Add the modifier 59 to 31502 Change of windpipe airway . Replace 31599 Larynx surgery procedure with 31526 Diagnostic Laryngoscopy for Laryngoscopy procedure. Add 31622 for Bronchoscopy.
The Marriage

Revenue Codes, CPT HCPCS Modifiers G/L, Price

ICD 9 Dx ICD 9 Proc DRG’S, CPT HCPCS Modifiers

CDM

HIM
Revenue Cycle Improvements

• Coding/Charge Capture
  – Identify training opportunities
  – Updated charge sheets
  – Capture lost revenue normally charged by nursing
  – Capture lost revenue due to coding to specificity
  – Capture lost charges for insertion/removal
  – Identify systematic errors leading to lost coding
  – Identify lost reimbursement due to human errors
Compliance - Document Drug Waste

• Missing some of the medication administration records
  – Include all medication administration records

• Number of units documented ≠ number of units billed
  – Verify dosage administered with units billed per code description
  – Be sure to document for single dosage vials if wastage necessary
    • How much administered and how much wasted
    • May bill total units or wasted units with JW modifier
    • Reference www.NGSMedicare.com Choose Education and Support
      – Choose Clinical Education
      – Choose Clarification on use of Modifier JW and Billing Drug Wastage Based on Change Request 6711

Risk - Pharmacy

• Billing for single use vials without documenting waste
• Pharmacy formulary not billing units properly
• Billing drugs at a unit of 1
• Billing drugs without the HCPCS code
• Lost revenue on high cost drugs
Revenue Cycle

• Pharmacy
  – Single Use Vials (SUV): Create process to document waste in the MR
  – Not SUV: Validate billed units reflect administered dosage
  – Validate billed units are calculated accurate to HCPCS dose
  – Recoup dollars lost to Medically Unlikely Edits (MUEs)
Where to begin?

- Know your audit risk areas
  - Use results from any and all audits
  - Algorithms of data
    - Mutually exclusive codes
    - High dollar CPT
    - Nonspecific codes
    - Normal billed quantities or minimum billed
    - Reimbursement outlier whether over/under norm
  - Random sampling
  - Use tracing
Don’t Forget

CHER If I Could Turn Back Time
4 Year Clerical Reopening

10.4 - Reopenings Based on Clerical or Minor Errors and Omissions
(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

Section 937 of the Medicare Modernization Act required CMS to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. We equate the MMA’s minor error or omission to fall under our definition of clerical error, located in §405.980 (a) (3). We believe that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, § 405.927 and §405.980 (a)(3) require that clerical errors be processed as reopenings rather than appeals. CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

The law provides that reopenings may be done to correct minor errors or omissions, that is, clerical errors. The contractor has discretion in determining what meets this definition and therefore, what could be corrected through a reopening.
DDE/FFISS Clerical Payment

MAP1741  MEDICARE PART A - JE PROD  ACPFA046 10/28/13
KRA6012  SC  CLAIM SUMMARY INQUIRY  C201341P 11:40:11

NPI

HIC  PROVIDER  S/LOC  TOB
OPERATOR ID  FROM DATE 031610  TO DATE 031710  DDE SORT

MEDICAL REVIEW SELECT

HIC  PROV/MRN  S/LOC  TOB  ADM DT  FRM DT  THRU DT  DT  CAN DT  REAS  NPC  #DAYS
SEI  LAST NAME  FIRST  INIT  TOT  CHG  PROV REIMB  PD  DT  CAN  DT  REAS  NPC  #DAYS

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050625  P B9997  13I  031610  031610  031710  072811  219004.46  12278.36  080511  092413  37205

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PROCESS COMPLETED  ---  PLEASE CONTINUE
PRESS PF3 EXIT  PF5 SCROLL BKWD  PF6 SCROLL FWD

VAUGHAN
HOLLAND
CONSULTING, INC.

hfma  first illinois chapter
healthcare financial management association
What Mercy gained through a Retrospective Review
**Transforming the Health of Our Communities**

Mercy is the sixth largest Catholic health care system in the U.S. and serves more than 3 million people annually. We are a highly integrated organization that includes 32 hospitals, 300 outpatient locations, 39,000 co-workers and 3,900 integrated physicians in Arkansas, Kansas, Missouri and Oklahoma. We also have outreach ministries in Louisiana, Mississippi and Texas.

**Mercy Hospitals**

Mercy operates acute care, specialty care and critical access hospitals in communities across four states:

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<tr>
<th>Arkansas</th>
<th>Kansas</th>
<th>Missouri</th>
<th>Oklahoma</th>
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### Revenue Recoveries by Month in Calendar Year 2013

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<tr>
<th></th>
<th>2013-6</th>
<th>2013-7</th>
<th>2013-8</th>
<th>2013-9</th>
<th>2013-10</th>
<th>Grand Total</th>
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<tr>
<td><strong>IP</strong></td>
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# Estimated Revenue Recoveries Currently In-Process

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<th>DEPARTMENT</th>
<th>NEW PS&amp;R DATA</th>
<th>VHCI CLAIMS UNDER AUDIT</th>
<th>RECOVERIES UNDER REVIEW BY CLIENT</th>
<th>BILLING</th>
<th>PAID PENDING INVOICE</th>
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<td><strong>$252,590</strong></td>
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Success

• Support from the top down
• Assign a project champion
  – Ownership of the process
  – Tracks status
  – Keeps it moving
• Have dedicated staff
• Accountability
• Create a system of reporting
Questions?

Meet Kathi Austin with Mercy Hospitals. She is our dedicated project Champion for VHCl revenue recovery effort. Do you have any questions on the process created or project results?

Contact Information:
Kathi L. Austin, CPC, CPC-H, CCP
Executive Director, MRM Revenue Integrity
Mercy
645 Maryville Ctr. Ste 100 | St. Louis, Mo. 63141
Find us at:
Facebook | Twitter | YouTube | mercy.net | Mercy Careers