

A close-up photograph of a person's eyes, looking slightly to the right. The eyes are light-colored, and the skin is fair. The lighting is soft, highlighting the texture of the skin and the details of the eyelashes.

*When Response  
Time Matters Most.*

**Documentation...**  
**The Key to Recovery Audit  
Contractor Survival**

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# Learning Objectives

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- Understand physician place of service coding / billing issues
- Physician vulnerable areas as identified by Recovery Audit Contractors (RAC)
- High-Risk Inpatient Vulnerabilities identified by Recovery Audit Program (RAP)
- Medical Necessity requirements
- CMS reminders to providers

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# Physician Issues

# Physician Issues

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- Physician types affected:
  - All physicians submitting Fee-for-Service claims to:
    - Medicare Carriers
    - Part A/B Medicare Administrative Contractors

# Physician Vulnerability

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- Duplicate claims
- New patient E/M services for the same beneficiary within a 3-year period
- E/M services billed by the surgeon
  - Day before procedure
  - Day of procedure
  - Within 90 days after major surgery
  - Within 0-10 days after minor surgery

# Physician Vulnerability (continued)

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- Incorrect number of units for Current Procedural Terminology (CPT) code billed based on:
  - CPT code descriptor
  - Reporting instructions in the CPT book and/or other CMS local or national policy

# Physician Improper Payments

Item	Provider Type	Improper Payment Amount (pre-appeal)	RAC Demonstration Findings
1	Physician	\$6,635,558	Other Services with Excessive Units – Units billed exceeded the number of units per day based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy.
2	Physician	\$1,094,751	Duplicate Claims – Physician billed and was paid for two claims for the same beneficiary, for the same date of service, same CPT code, and same physician.

*Note: The two findings identified in the above table impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.*

# Physician Overpayment

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- Centers for Medicare and Medicaid Services consider a physician overpayment exists when the physician bills and is paid for services that have been previously processed and paid.
- Sources:  
Medicare Financial Management Manual Chapter 3,  
Section 10.2  
<http://www.cms.gov/manuals/downloads/fin106c03.pdf>

# Office of Inspector General (OIG)

## Findings of Physician Billing

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- The following two issues resulted in physician billing overpayments:
  - Physicians incorrectly coding place-of-service codes
  - Physicians are incorrectly using non-facility place-of-service codes that were performed in outpatient or Ambulatory Surgery Centers
  
- Sources:
  - <http://www.cms.gov/PlaceofServiceCodes/>
  - <http://oig.hhs.gov/oas/reports/region1/10900503.asp/>

# CMS Reminders to Physicians

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- It is inappropriate to routinely submit duplicate claims to Part B Carriers and MACs for a single service encounter
- Bill using the appropriate CPT code
- Accurately report the units of service
- Ensure that the units billed do not exceed the number of units per day based on CPT code descriptor, instructions in the CPT book, and/or CMS local or national policy

# Physician Place of Service Billing

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- CMS reminds physicians and billing agents of:
  - The importance of correctly coding the place of service
  - Implementing appropriate controls to prevent incorrect place of service billing
  - The use of non-facility place-of-service codes for services performed in outpatient or Ambulatory Surgical Centers (ASC) results in overpayments
  - Physician responsibility for any Medicare claims submitted by billing agents
- CMS expects the physician to:
  - Correctly code the place of service on Part B claims
  - Insure adequate controls are in place to identify potential place-of-service coding errors

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# High-Risk Inpatient Issues

# Inpatient Denials

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- Provider types affected:
  - All Inpatient Hospital providers submitting fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs)
- Inpatient vulnerable areas identified by Recovery Audit Contractors
  - Medical necessity for multiple codes
  - Ambulatory Surgery coding errors paid at inpatient rate instead of outpatient rate
  - Outpatient charges that were not billed because medical services were not necessary for inpatient

# RAC Inpatient Findings

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- Denied because services were not medically necessary for setting billed
- Service/procedure was medically necessary but not as an inpatient setting

# 20 DRGs Identified as Inpatient Provider Medical Necessity Vulnerability

Table I

	Provider Type	Improper Payment Amount (pre-appeal)	RAC Demonstration Findings
1	Inpatient Hospital	\$64,739,662	Cardiac Defibrillator Implant (DRG 514/515)
2	Inpatient Hospital	\$34,155,158	Heart Failure and Shock (DRG 127)
3	Inpatient Hospital	\$21,956,139	Other Cardiac Pacemaker Implantation (DRG 116)
4	Inpatient Hospital	\$19,169,815	Chest Pain (DRG 143)
5	Inpatient Hospital	\$14,374,696	Misc. Digestive Disorders (DRG 182)
6	Inpatient Hospital	\$13,881,479	Other Vascular Procedure (DRG 478)
7	Inpatient Hospital	\$10,359,085	COPD (DRG 88)
8	Inpatient Hospital	\$9,978,346	Medical Back Problems (DRG 243)
9	Inpatient Hospital	\$8,467,551	Renal Failure (DRG 316)
10	Inpatient Hospital	\$7,355,002	Nutritional & Misc. Metabolic Disorders (DRG 296)
11	Inpatient Hospital	\$6,979,129	Transient Ischemia (DRG 524)
12	Inpatient Hospital	\$6,689,870	Syncope & Collapse (DRG 141)
13	Inpatient Hospital	\$6,228,919	Other Circulatory System Diagnoses (DRG 144)
14	Inpatient Hospital	\$4,758,678	Kidney & UTI (DRG 320)
15	Inpatient Hospital	\$3,239,751	Cardiac Arrhythmia (with CC DRG-138)
16	Inpatient Hospital	\$3,191,084	Red Blood Cell Disorder (DRG 395)
17	Inpatient Hospital	\$2,912,155	Degenerative Nervous System Disorders (DRG 012)
18	Inpatient Hospital	\$2,889,840	Atherosclerosis (with CC DRG-132)
19	Inpatient Hospital	\$2,545,289	Other Digestive System Diagnosis (DRG 188)
20	Inpatient Hospital	\$2,314,001	Percutaneous Cardiac Procedure (DRG 517)

## Disclaimer

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Source:

MLN Matters® Number SE1027

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# Medical Necessity

# Medical Necessity Denials - Inpatient

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- Documentation *did not*:
  - Support diagnosis
  - Justify the treatment or procedure
  - Document the course of care
  - Identify treatment or diagnostic test results
  - Promote continuity of care among health care providers

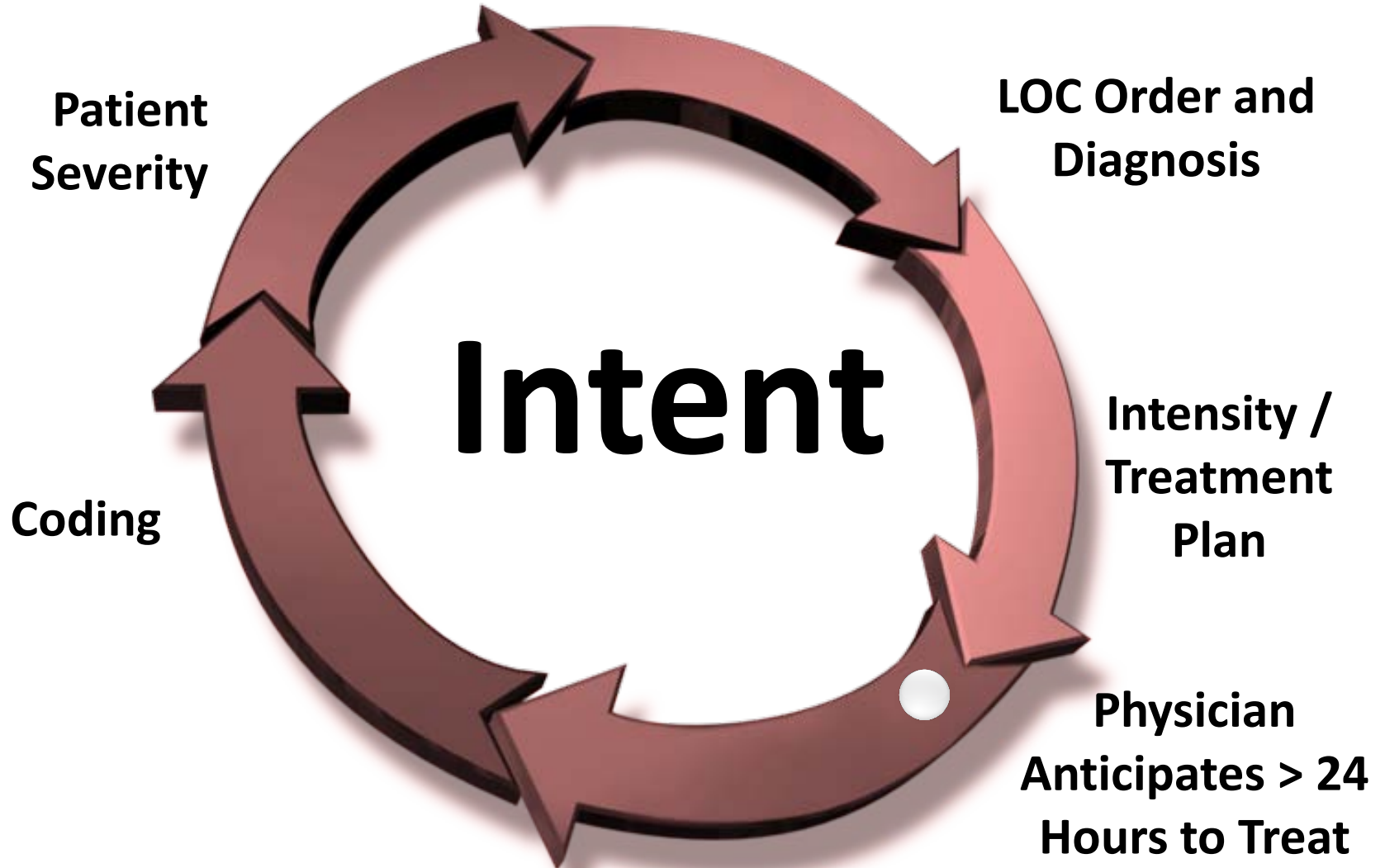
# Factors to Consider Inpatient Medical Necessity

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- The severity of the signs and symptoms exhibited by the patient
- Medical predictability of something adverse happening to the patient
- The need for diagnostic studies
- Availability of diagnostic procedures at the time when and at the location where the patient presents
- Pre-existing medical problems that make admission medically necessary

# Summary – Medical Necessity Documentation

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# CMS reminders to providers

# CMS Reminders to Providers

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- The medical record must contain sufficient documentation to demonstrate signs and symptoms were severe enough to warrant inpatient medical care  
<http://www.cms.gov/manuals/downloads/pim83c06.pdf>
- Admissions are not covered or non-covered solely on basis of time  
<http://www.cms.gov/manuals/downloads/bp102c01.pdf>
- Comply with Inpatient Hospital coding clinic guidelines

# CMS Reminders to Providers (continued)

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- Legibility has a direct affect on RAC reviewer's ability to support medical necessity and appropriate setting
- Complete all fields on documentation tools
- If a field is not applicable use "N/A"
- Medicare contractors may use clinical judgment
  
- Source:  
Program Integrity Manual Chapter 3, Section 3.14<http://www.cms.gov/manuals/downloads/pim83c03.pdf>

# CMS Reminders to Providers (continued)

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- Ensure all entries are consistent with other parts of the medical record
- Document significant changes in the condition or care of the patient
- Ensure information that affects the billed services acquired after physician documentation is complete is added according to accepted standards for amending medical record documentation

# Questions

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# References

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- Included in the body of presentation