

Audio Title: Recovery Audit Program (RAP) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals
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Welcome to Medicare Learning Network Podcasts at the Centers for Medicare and Medicaid Services, or “CMS”. These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for Medicare Fee-For-Service providers.

This podcast gives you information on the CMS Recovery Audit Program, or “R-A-P,” and its findings that contribute to improper Medicare payments.

If you are an Inpatient Hospital provider who submits Medicare Fee-For-Service claims to your Medicare Contractors, or “MACs,” you will benefit from this podcast! There are steps you can take to avoid denial of your claims, including accurately documenting medical services to support your claims. We will discuss some of the 17 findings identified by the “R-A-P” in an effort to prevent future improper payment issues. It is essential that you understand “lessons learned” and also, implement corrective actions resulting from the R-A-P expansion and the initiation of complex medical review.

Consider this important information and take necessary steps to meet Medicare documentation requirements. This avoids DENIAL of your claims!

CMS directed the R-A-P to identify the effectiveness of Medicare payment recovery auditing in reducing improper payments. As the R-A-P strives to attain this primary goal, supplemental goals emerge.

CMS collects improper payment information from the R-A-Ps at the claims level. Topping the list of findings are the following four (4) improper payments:

- Chest Pain at \$19.1 M,
- Other Cardiac Pacemaker Implantation at \$21.9 M,
- Heart Failure and Shock at \$34.1 M and,
- The largest improper payment, Cardiac Defibrillator Implant at \$64.7M!

CMS denied these claims because the related documentation submitted did not support inpatient hospital services. Also, the services billed were not medically necessary in inpatient hospital settings.

If you would like to review all 17 findings identified by the R-A-Ps, go to the MLN Matters Articles web page at www.cms.gov/MLN MattersArticles and look for Special Edition article number SE1027. Please note, this list of findings DOES NOT include appeal results.



The R-A-Ps identify the following three (3) types of denials:

- First, Medical necessity denials for multiple codes,
- Second, Ambulatory Surgical Center coding errors paid at the inpatient rate rather than the outpatient rate; and
- Third, other outpatient charges that were not billed because the medical services provided were not medically necessary in the inpatient hospital setting.

These categories of medical necessity denials impact multiple codes with no coding trends. CMS denied these claims because the medical documentation submitted did not:

- One (1) - Support the diagnosis,
- Two (2) - Justify the treatment or procedures,
- Three (3) - Document the course of care,
- Four (4) - Identify treatment or diagnostic test results and,
- Five (5) - Promote continuity of care among health care providers.

CMS identifies the following two (2) reminders for Inpatient Hospital Medical Documentation to justify Medicare Claims Payment:

- One (1): the medical record must contain sufficient documentation to demonstrate that the patient's signs and symptoms were severe enough to require inpatient hospital medical care.
- Two (2): you should document any pre-existing medical problems or extenuating circumstances that make the beneficiary's admission medically necessary. Factors resulting in a simple inconvenience to the beneficiary are not enough to justify an inpatient admission. The beneficiary requires inpatient care only if his or her medical condition, safety, or health would be significantly and directly threatened in a less intensive setting.

Four basic factors to consider when making the decision to admit the patient are:

- Number one (1): The severity of the signs and symptoms exhibited.
- Number two (2): The medical predictability of an adverse happening to the patient.
- Three (3): The need for diagnostic studies; and
- Four (4): The availability of diagnostic procedures at the time and location where the patient presents.

CMS does not base Medicare coverage solely on the length of time the patient was in the hospital.

Non-legible documentation affects the R-A-P reviewer's ability to support the medical necessity and appropriate setting of the billed services. CMS encourages providers to complete all fields on documentation tools, such as assessments, flow sheets, and checklists. If a field is not applicable, CMS recommends use of "N/A" (or, "Not Applicable") to show you reviewed and answered each question. Fields that you leave blank can lead the reviewer to make an inaccurate claim determination.

CMS encourages you to comply with inpatient hospital policy and Coding Clinic guidance. In the absence of a specific Medicare Policy, Medicare contractors may use clinical review judgment to make a payment determination.



During the review of R-A-P data, reviewers noted that entries in the medical records were inconsistent. CMS encourages you to ensure that all entries ARE consistent with other parts of the medical record, including but not limited to:

- Assessments,
- Treatment plans,
- Physician orders,
- Nursing notes,
- Medication and treatment records,
- And other documentation, such as admission and discharge data and Pharmacy records.

If you make an entry that contradicts previous documentation, CMS recommends that you include documentation explaining the contradiction.

R-A-P review staff often noted that providers failed to adequately document significant changes in the patient's condition or care that could impact the review determination. CMS recommends that you document any changes in the patient's condition or care.

Lastly, CMS reminds you to add any information that affects the billed services and also, is acquired after physician documentation is complete. This complies with accepted standards for amending medical record documentation.

For more information about the improper Medicare payment findings and updates on the National Recovery Audit Program, please visit the CMS R-A-P website at www.cms.gov/RAC. You may register to receive email updates and view current nationwide R-A-P activities through this website.

More questions? Contact your Medicare contractor or visit our website www.cms.gov/MLNGenInfo and follow the links to MLN Matters Articles and download the full article on this subject, #SE1027. Be on the lookout for information regarding future MLN podcasts.

This podcast was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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