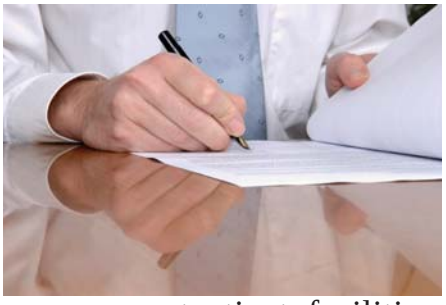
Health Care Visions News

Consultants Specializing in Cardiovascular Programs 4th Quarter 2008

What to Expect from Recovery Audit Contractors

Appropriate coding and billing for patient care services has always been a complex and time/resource intensive process as hospitals struggle to keep abreast of new codes, regulations and changes in fee payment schedules. With the implementation of the CMS recovery audit contractors (RAC) demonstration project, it is now critical for hospitals to dedicate even more attention to ensure correct coding and billing. The RAC demonstration project (initiated under the 2003 Medicare Modernization Act) has reaped significant financial returns to CMS and thus the scope has been expanded in 2007 and 2008 with plans for all states to be included by January 2010.

Initially, in 2005 three states (Florida, California and New York) were selected for the demonstration project with expansion to Massachusetts, Arizona and South Carolina in 2007. Other groups of states are scheduled to be "phased in" over the course of the next 12 to 14 months. Of note, it is not only inpatient facilities that are involved in this auditing



process; outpatient facilities, physician offices and durable medical equipment (DME) providers are also being reviewed.

Prior to this demonstration project, less than 5% of all claims to CMS were reviewed by Medicare Administrative Contractors (MAC). In this small percentage of claims, an error rate of 6 to 10% was noted. Results indicated CMS was reimbursing a huge amount of dollars in overpayments. The demonstration project enlists private recovery auditing firms to review charts and determine errors. As these RACs are paid on a percentage of dollars they recover, the chart audits are aggressive and thorough. Although articles quote varied recovered amounts, at least $350 million dollars in overpayments have been recovered from the three initial states in the demonstration project. In the reviews approximately 96% of the errors were overpayments and only 4% were underpayments. This has great financial implications for a facility if large numbers of overpayments must be refunded. When reviewing the overpayments, it was determined that the majority (85%) were collected from inpatient hospitals, 6% from inpatient rehabilitation facilities, 4% from outpatient providers and the other 5% from either DME or physician office practices.

Some major areas of concentration for the RAC audits have included:

- One day stays (inpatient facilities)
- Pharmaceutical coding and number of units (in facilities as well as physician offices)
- Medical necessity of services and admissions
- Discharge codes
- Incorrect coding

Improper payments were

Continued on Page 3

No More Atrial Fibrillation!

My Post Ablation Update

Barb Sallo

So far--so good. Since my left atrial ablation for recurrent atrial fibrillation was performed in August, I have not had any episodes of atrial fib. It is nice to be in normal sinus rhythm and I have quit wondering "how long will this last?" I am glad that I had the procedure but as my physician said "it was no walk in the park."

I was admitted to the hospital on August 25th for a transesophageal echocardiogram (TEE) to ensure that blood clots were not present in my heart chambers and an enhanced cardiac CT was performed to provide a map of my heart's physiology. Following clearance by those tests, IV heparin was initiated requiring an overnight stay before the ablation. On August 26th the ablation was performed taking several hours, requiring anesthesia and a lengthy stay in the EP lab.

The vascular sheaths remained in place overnight due to the heparin received post procedure and the increased potential for bleeding. Three sheaths were in my right groin (two venous, one arterial) and one sheath in my left groin. On August 27th the sheaths were removed and I was given more conscious sedation.

Three days of anesthesia/sedation resulted in a severe headache. Body aches (from the time on the procedure table) seemed insignificant compared to the headache. I also experienced some significant lower abdominal bruises and a drop in H & H. Following discharge, it took a couple of weeks to begin feeling energetic but that was probably a good thing—since it was suggested that I "take it easy."

Looking back, having this procedure was definitely worth it. Previously I had never gone longer than three days without an atrial fibrillation episode and the chest palpitations were a nuisance. I will remain on Warfarin and antiarrhythmic medication for another month.

The Graying Population

Age	2010	2020	2030	2040	2050
0-4	6.9%	6.8%	6.7%	6.7%	6.7%
5-19	20.0%	19.6%	19.5%	19.2%	19.3%
20-44	33.8%	32.3%	31.6%	31.0%	31.2%
45-64	26.2%	24.9%	22.6%	22.6%	22.2%
65-84	11.0%	14.1%	17.0%	16.5%	15.7%
85+	2.0%	2.2%	2.6%	3.9%	5.0%

Source www.hhnmag.com; 7/08

Americans are living longer and the nation is getting older. In 2007, there were 37.9 million Americans ages 65 or older. They represented 12.6 percent of the population. By 2030, the number of older people is expected to increase by 88.6 percent to 71.5 million, totaling 20 percent of the population.

What to Expect from Recovery Audit Contractors (con't)

attributed primarily to three types of errors: services coded incorrectly (did not code appropriately for the procedure performed), duplicative claims and payment based on an outdated fee schedule.

Once RAC audits are initiated in your state, they are limited to reviewing claims within the last three years (from the date the claim was originally paid) and cannot review claims paid earlier than October 1, 2007. Thus, hospitals are somewhat shielded from a vast retrospective review greater than three years. Although this does act as a financial shield to a limited degree, a provider who suspects coding and billing issues needs to quickly give priority attention to improving this or risk a potentially large financial hit if auditing exposes coding and billing errors. If your facility is audited and over or incorrect billing is discovered, there is a hospital appeal process. The appeals rate (from a July 2008 update report from CMS) was 19.6% and the overturn rate in favor of providers for appealed denials was 35%.

If your state is not currently under RAC audit review, it would make good business sense to begin preparing for its impending implementation by taking a long hard look at your coding and billing process, reviewing and updating your charge description master and providing education to both staff and physicians on the importance of quality documentation to support the charging, coding and medical necessity billing components.

Making Changes

Below are just a few of the changes CMS made to the permanent RAC program:

Issue	*Demonstration*	*Permanent Program*
Medical director on RAC staff	*Not required*	*Mandatory*
Coding expert on RAC staff	*Optional*	*Mandatory*
Credentials of RAC reviewers provided upon request	*Not required*	*Mandatory*
RAC must pay back contingency fee if the claim is overturned on appeal	*Only required if the claim is overturned at the first level of appeal*	*Required at all levels of appeal*
Public disclosure of contingency fees	*No*	*Yes*
Look-back period	*4 years*	*3 years*
Maximum look-back date	*None*	*October 1, 2007*
Limits on number of claims a RAC can request	*Optional, set by each RAC*	*Mandatory, to be set by CMS*
Claims status web site	*Not required*	*Live by January 2010*

Source: The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-year Demonstration, CMS, June 2008

Studies & Articles of Interest

1. How to Have a Younger Heart

The American Journal of Physiology, June 20th online version suggests endurance training. Older adults who walk, run or bicycle three to five days a week for about an hour per session can improve their heart's ability to convert glucose into energy during high demand, just as younger hearts do. In the study a dozen men and women ages 60 to 75 who had been living an inactive lifestyle participated in an 11-month endurance exercise program. By the end of the study period, glucose conversion had doubled in the participants, indicating their hearts were pumping efficiently helping to protect them against ischemia and heart attack.

2. Prevention for a Healthier America

A report released by Trust for America's Health in July 2008 found that a small strategic investment in disease prevention could result in significant savings in U.S. health care costs. In it's report, entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, TFAH concluded that an investment of $10 per person per year could save the country more than $16 billion annually within five years. The results are presented in a state-by-state breakdown.

3. Drug Eluting Stents

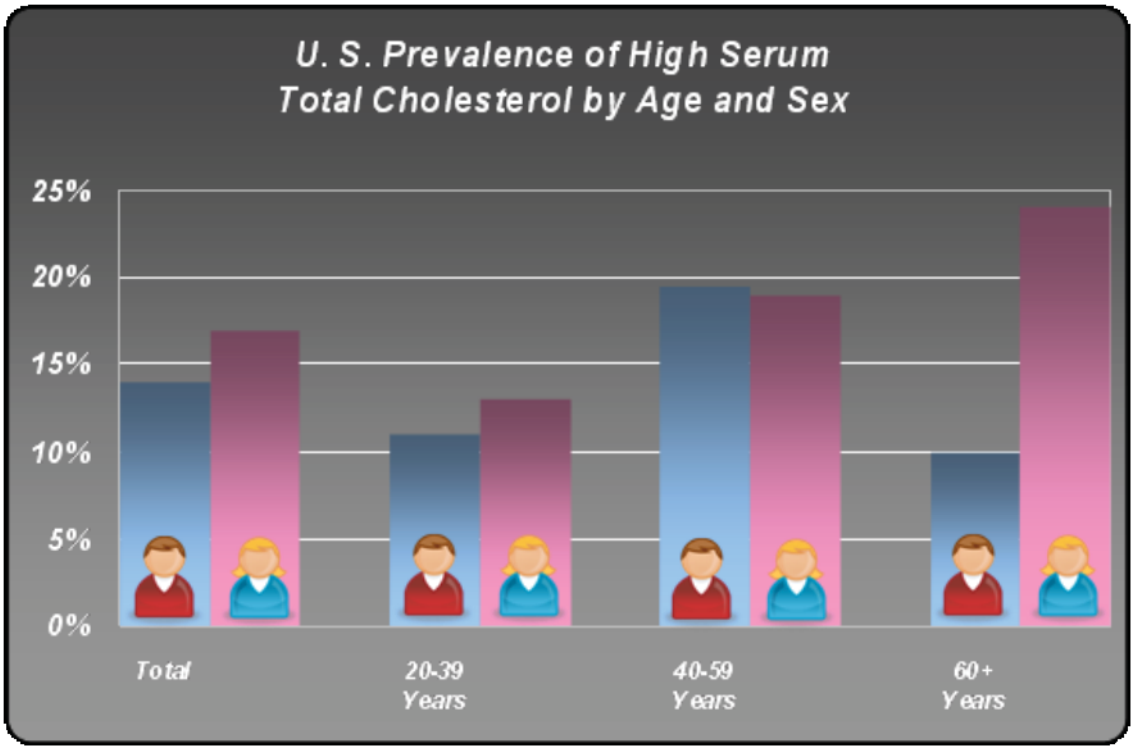
A recent study published in the J*ournal of the American Medical Association* (2008;299[24]:2868-2876) found that the widespread use of DES is associated with a decrease in repeat procedures and does not appear to increase the risk of death when compared to bare metal stents. In a study of 39,000 Medicare patients, the researchers found that 22.8 percent of patients in the BMS group underwent a repeat revascularization compared to 19 percent of patients in the DES group during a two-year follow up.

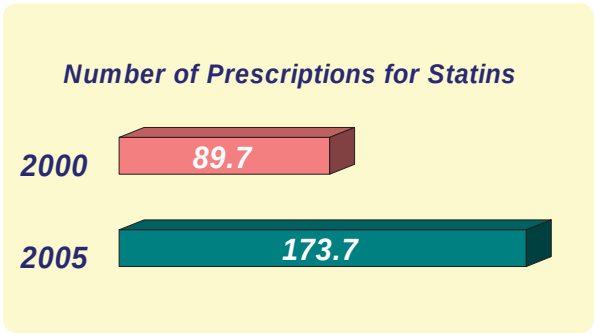
4. Death Rates Fall, Life Expectancy Increases

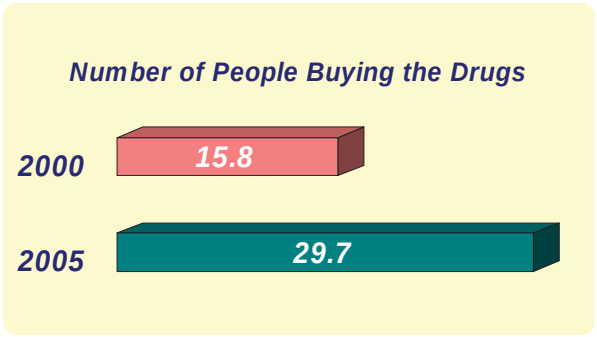
Age-adjusted death rates in the United States declined significantly between 2005 and 2006 while life expectancy hit another record high, according to the Centers for Disease Control and Prevention's National Center for Health Statistics. The age-adjusted death rate fell from 799 deaths per 100,000 population in 2005 to 776.4 in 2006. Heart disease decreased by 5.5% while life expectancy increased 0.3% to a record high in 2006 of 78.1 years.

5. Outpatient Cath Labs Facing Severe Reimbursement Decreases from CMS

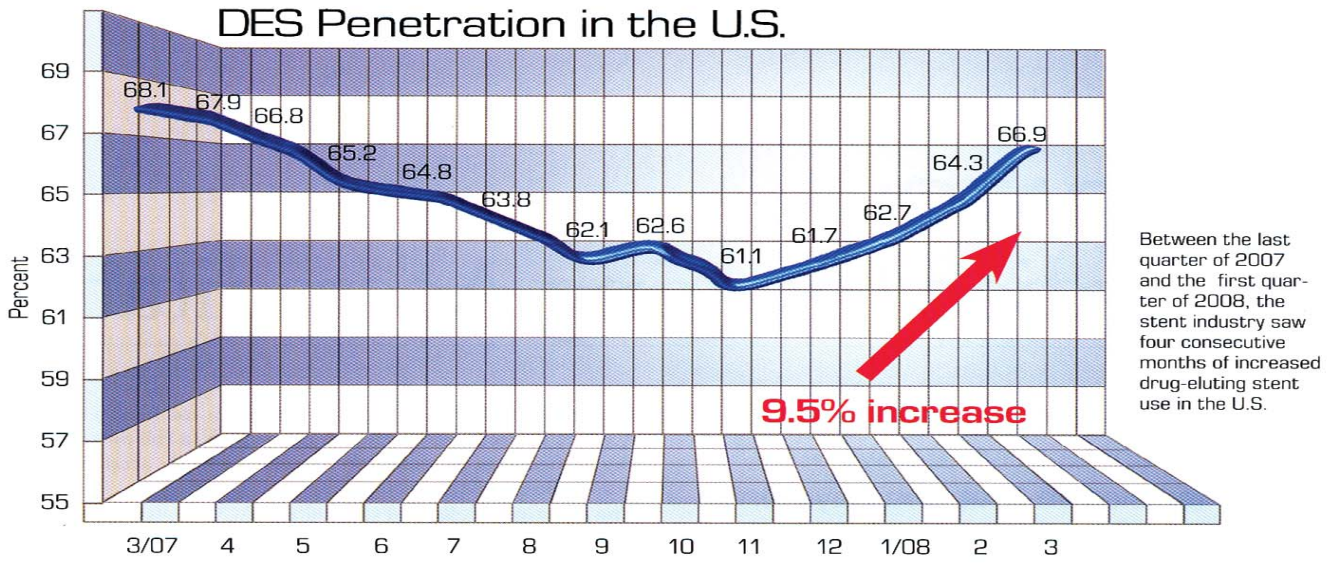
As reported in the *Cardiovascular Business Times* (Sept/Oct 2008, page 40), the 2009 Medicare fee schedule does nothing to reverse the steep cuts to outpatient cath labs that were first outlined in the 2007 fee schedule. "Reimbursement for catheterization procedures performed in a non hospital setting will be reduced by 47 percent by 2010—beginning with the 23 percent cut that took effect in January 2008," as stated in the article.







Source: Center for Financing, Access and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2000-2005



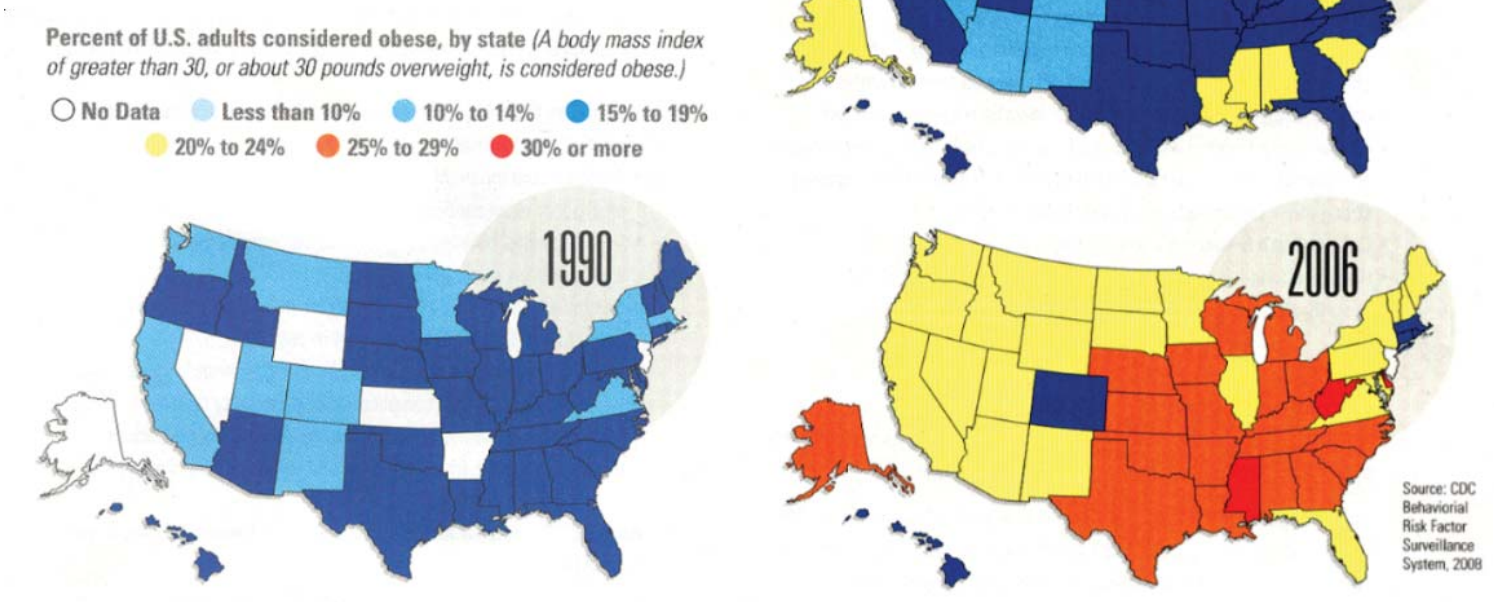
Source: Cardiovascular Business, Sept./Oct. 2008

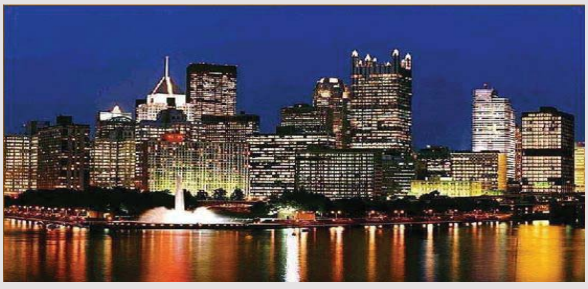
Obesity At It's Worst

A report released last month by the Robert Wood Johnson Foundation: *F as in Fat: How Obesity Policies Are Failing In America 2008* declares obesity to be one of the most serious health problems in the U.S. The report notes that adult obesity rates have doubled since 1980—from 15 percent to 30 percent, that two-thirds of adults are now either overweight or obese.

A Growing Problem

Obesity has risen dramatically in the United States during the past two decades. In 2006, 22 states had a prevalence of obesity equal to or grater than 25%. Just four states had a prevalence of less than 20%, according to the centers for Disease Control and Prevention.





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