

MEDICARE COMPLIANCE

CMS Cites Medical-Necessity Problems With 17 DRGs, Urges Better Documentation

In new guidance, CMS warns hospitals that 17 DRGs are at high risk of claims denial because “the services were not medically necessary for the setting billed.”

Patients could have been treated in a less-intensive setting, such as observation, rather than an inpatient bed — or at least that’s what the documentation indicates in the claims analyzed by recovery audit contractors (RACs) — CMS said in a new *MLN Matters* article (SE 1027).

To support admissions, hospitals should ensure that their documentation is legible and complete, CMS states, and that “all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed,” which is probably a reference to electronic medical record integrity (*RMC 9/27/10, p. 1*).

CMS described the dollar impact of site-of-service errors with the DRGs, such as digestive disorders and cardiac defibrillator implants, during the three-year RAC demonstration (see DRG list, p. 6). The DRGs cited in the *MLN Matters* are among the DRGs now targeted by the four RACs in the national program. CMS says it’s providing the information on “high dollar improper payment vulnerabilities” to educate hospitals and help them prevent the same problems down the road.

Both RACs and Medicare administrative contractors are scrutinizing these DRGs, so documentation should be a top compliance priority.

But the astronomical improper payments cited by CMS in the article aren’t necessarily the final word. Because the figures listed represent pre-appeal dollars, some of the denied claims may have been overturned in hospitals’ favor through Medicare appeals.

“Our experience in the Medicare appeals process suggests that many of the denials associated with target areas high on the [*MLN Matters*] list, such as cardiac defibrillator implantation, heart failure and chest pain, were reversed in the appeals process — especially at the administrative law judge level,” says Michael Taylor, M.D., vice president of clinical operations for Executive Health Resources in Philadelphia. “Providers should assess each denied claim on its individual merits. While lists of high-risk DRG targets such as these are good

starting points for providers initiating self-audits, the inclusion or absence of a particular DRG on a list of high-risk targets should not be the definitive factor for providers who are considering appeal. The decision whether or not to appeal a denial should be made based on the clinical and legal merits of the case.”

CMS says inpatient claims for the high-risk DRGs were often denied because medical records didn’t have enough information to support the diagnosis, justify treatment and/or procedures, document the course of care, identify the results of treatment or diagnostic tests, and facilitate continuity of care among providers.

“Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting,” the article notes. (See Chapter 6, Section 6.5.2 of Medicare’s Program Integrity Manual at www.cms.gov/manuals/downloads/pim83c06.pdf.)

One of the DRGs on the CMS high-risk list is medical back problems, which is a long-time medical-necessity target of Medicare auditors. Because many back-pain patients can be treated as outpatients, documentation must thoroughly establish when admissions for this DRG are warranted, Taylor says. Legitimate reasons for inpatient treatment of back problems could include potential injuries to the nervous system that endanger the patient’s spinal cord, causing paralysis or weakness of extremities, Taylor says.

“It’s important in the documentation to differentiate potential neurological injuries or injuries that require more intensive care from lower-intensity pain or muscle spasms that indicate far less risk to patients,” he says. Sometimes hospitals mistakenly think patients meet inpatient admission criteria (e.g., InterQual) for medical back problems when they don’t. The patient may not be ambulating due to pain and muscle spasm, “but that’s not true paralysis,” Taylor says. “The admission criteria frequently look toward neurological injury rather than ambulatory dysfunction due to lumbar muscle spasm and pain. Hospitals that fail

to differentiate between those two groups of patients [may face denials for medical back problems].”

Pain Management Can Be Tricky

It is also important to be wary of admissions for pain management. “We see some hospitals routinely admitting patients for low-risk, low-intensity, short-duration pain control,” Taylor says. Patients who require prolonged or high doses of intravenous narcotics may be appropriate admissions, especially if they have comorbid conditions, he says. But many patients can be treated with oral medications in the emergency department or with observation services. Whichever route you choose, “the physician has to evaluate each patient on a case-by-case basis and arrive at an informed decision and document very thoroughly to demonstrate the rationale behind his or her admission status decision,” Taylor says.

Another DRG on the CMS high-risk list is cardiac defibrillator implant, a surgical DRG. Implantable cardiac defibrillators are small electronic devices that shock the heart during life-threatening tachyarrhythmias (abnormal electronic activity). They have attracted the attention of the Department of Justice, which is investigating hospitals in multiple states for cardiac defibrillator surgery, apparently both over medical necessity and DRG coding (*RMC 4/26/10, p. 1*).

Taylor says hospitals must ensure that their documentation shows the patient needs the device and that the correct setting — inpatient or outpatient — was the right choice for the surgery. “You have to document both the initial need for the defibrillator implant and the correct status,” he says.

The chart also has to show that patients meet the Medicare national coverage determination (NCD) for cardiac defibrillator implants, Taylor says. “If you don’t meet that, Medicare won’t pay for the procedure,” he says. The NCD (20.4) describes the conditions for which Medicare covers cardiac defibrillator implantation (e.g., cardiac arrest due to ventricular fibrillation; coronary artery disease with a documented prior myocardial infarction; documented sustained ventricular tachyarrhythmia).

When Taylor examines hospital charts, he sometimes finds that physicians fail to explicitly communicate the extent of the patient’s heart failure. “Physicians have to describe exactly what procedure is being performed,” he says. For example, if the patient needs a dual-chamber device, physicians should describe the reasons why — “especially if the patient needs biventricular devices for resynchronization therapy,” which provides electrical stimulation to both chambers of the heart. “The physician has to document that the patient had such severe congestive heart failure that resyn-

High-Risk DRGs: CMS List of Common Site-of-Service Errors

In a new *MLN Matters* article (SE1027), CMS lists some of the DRGs that were prone to claims denials during the RAC demonstration because documentation did not support an inpatient level of care. Many of these DRGs are now appearing on the four national RACs’ target lists. To read the article, go to AIS’s Government Resources at the Compliance Channel at www.AISHealth.com; click on “CMS’s MLN Articles.”

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

chronization is appropriate therapy, which requires in-depth notes on the degree and severity of the heart failure," he says. Beyond that, physicians must document comorbidities (i.e., other illnesses) that affect treatment and site-of-service decisions. Is the patient at high risk because of unstable medical conditions, such as uncontrolled diabetes or renal failure? "Without that specific level of documentation, hospitals could be denied for that admission," Taylor explains.

The DRG for transient ischemia, which means the brain briefly received inadequate oxygen, is also on the CMS hot seat, according to the *MLN Matters* article. Transient ischemia "can be a very dangerous situation, but some patients may be at much higher risk than others, so it's important to document clinical details," Taylor says, such as:

- ◆ The duration of a patient's symptoms;
- ◆ The patient's age;
- ◆ The exact clinical features of the symptoms;
- ◆ The patient's blood pressure;
- ◆ The patient's other comorbidities; and
- ◆ Risk factors. For example, does the patient have a history of cardiovascular or cerebrovascular disease? Is there a history of ischemia (restriction of blood supply)? Does the patient have diabetes mellitus?

Whether the patient is treated in an inpatient versus outpatient setting is a decision the physician should make on a case-by-case basis. "You can't have a one-size-fits-all approach." It's important to use evidence-based medicine, he adds. "Often these patients need close monitoring as well as aggressive diagnostic assessment and, in some cases, if certain problems are identified, such as acute obstruction, they may need much more aggressive treatment," Taylor says. While all this assessment and monitoring is going on, clinicians don't even know if the DRG will be transient ischemia. It could very well turn into a stroke. "Their DRG is not assigned yet," he notes. Given the fluid nature of the diagnosis, "you have to document the clinical details thoroughly to demonstrate the presence of medical necessity. Clinicians should document everything and let the coder sort out the DRG on the back end," he advises.

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