

MEDICARE COMPLIANCE

MS-DRGs Targeted in RAC Prepayment Demo Raise Red Flags Despite the Delay

Although CMS has postponed its RAC prepayment review demonstration, the MS-DRGs that face scrutiny are potential risk areas for all hospitals. They include syncope, which is a top cause of medically unnecessary admissions, and gastrointestinal bleeding, a RAC postpayment audit target.

At the same time, the delay in the RAC demonstration, announced Dec. 29, probably hasn't dampened CMS's enthusiasm for prepayment reviews, because they prevent overpayments instead of defaulting to after-the-fact recovery (*RMC 11/21/11, p. 1; 12/19/11, p. 1*).

"Prepayment review is a way to fix the error rate," George Mills, director of the CMS Provider Compliance Group, tells *RMC*. Medicare administrative contractors (MACs) are doing MS-DRG prepayment reviews around the country, he says, as well as prepayment reviews of other claim types based on findings from the Comprehensive Error Rate Testing (CERT) contractor. "We are focusing on where we can get the biggest bang for our buck."

Mills emphasizes, however, that hospitals won't be double-whammied — subject to a prepayment review and a postpayment review on the same claim. RACs and MACs are required to develop joint operating agreements, which include procedures "to ensure that a RAC and a MAC are not looking at the same provider at the same time for the same issue," he explains.

Whether there's prepayment or postpayment review by RACs and MACs, the process for defensible claims is the same, says Ralph Wuebker, M.D., vice president of the audit, compliance and education physician team at Executive Health Resources in Newtown Square, Pa.

It's a triad: physician documentation of the patient's condition and its implications; first-level screening by case managers for admission necessity; and second-level physician review. "If you have all the pieces in place, that will be the core of your defense, whether they review prepayment or three years down the line," Wuebker says.

When it resumes, the RAC prepayment demonstration will focus on both coding and admission necessity for eight

MS-DRGs, for starters. Even if the demo gets shelved, these MS-DRGs are risk areas:

- ◆ Syncope and collapse (MS-DRG 312),
- ◆ Transient ischemia (MS-DRG 069),
- ◆ Gastrointestinal hemorrhage with complications and comorbidities (MS-DRG 378),
- ◆ Gastrointestinal hemorrhage with major CC (MS-DRG 377),
- ◆ Gastrointestinal hemorrhage without CC/MCC (MS-DRG 379),
- ◆ Diabetes with MCC (MS-DRG 637),
- ◆ Diabetes with CC (MS-DRG 638),
- ◆ Diabetes without CC/MCC (MS-DRG 639).

Mills says it's unclear why syncope is a big problem. "However, based on national CERT data, there is a consistent trend that beneficiaries are admitted when their medical condition warrants observation when Medicare receives a short stay claim for syncope," he notes.

Documentation of Etiology Is Key

Physician documentation is the heart of compliance for all these MS-DRGs. "Physicians tend to focus on a symptom-based diagnosis instead of what is really going on with the patient," he says. With syncope, physicians may document the patient was weak and dizzy and needed IV fluids. But "what differentiates [inpatient and outpatient care] and keeps physicians out of trouble" is explaining the cause of the syncope for that patient. Is there a neurological or cardiac etiology, meaning the patient is at risk of stroke or heart attack? Or is inner ear infection the culprit? "Getting physicians to say 'here are my suspicions, here is what I am concerned about' is very significant," Wuebker says. They don't have to be right in the end; they just have to write, from the beginning, what symptoms may mean.

When it comes to documentation, the diabetes and gastrointestinal MS-DRGs in particular are tricky.

To support admissions for GI bleeds, physicians should bridge the gap between the patient's symptoms and the need for acute care (or observation placement),

Wuebker says. GI bleeding could be chronic, caused by a hemorrhoid or ulcer, or acute; “there’s a big difference if someone is living with a GI bleed from diverticulosis and losing a unit of blood every day and is lightheaded and dehydrated,” he says. It’s essential for physicians to document the pertinent clinical findings when they decided to admit the patient, and say “here is what is running through my thought process,” he says. Was the hemoglobin lower than a previous reading ordered at the doctor’s office? Is the heart rate higher?

When physicians don’t connect the dots, he will call them and say, “are you thinking colon cancer with this patient?” It requires teasing out their thoughts in a conversation that lasts two to four minutes. Auditors generally don’t do this, Wuebker says. “They usually focus on physician notes and typically don’t look at supporting information — nurses’ notes, lab reports — so if all the physician has written is a symptom and treatment plan,” auditors have no clear picture of what drove the physician to be concerned about the patient to the point of ordering admission.

Physicians have to tell the story, but that doesn’t mean they have to write a novel. A one-page history and physical in the progress notes could suffice as long as physicians include three to five sentences on their impressions and medical decision making. “That is very solid from a defense perspective and you will be more successful overall in the appeal process,” he says. But often that doesn’t happen.

For example, when patients are admitted through the emergency room with chest pain, often physicians will write “chest pain, EKGs, troponins, oxygen, stress test in the morning.” Little is mentioned about the physician’s worries, which are a big trigger for an admission. Is the chest pain probably from nachos and beer and the physician is being extra cautious? If so, auditors will expect that patient to be placed in observation. If the physician documents that he fears a heart attack, that’s a different story.

CMS Must See Diabetes Warning Signs

Diabetes as a site-of-service compliance risk came as a surprise because it’s not a classic compliance issue. The

CMS Program for Evaluating Payment Patterns Electronic Report (PEPPER) doesn’t include diabetes, although at least one RAC is auditing inpatient medical necessity for diabetes on a postpayment basis. Obviously, though, CMS has data indicating there are admission troubles in this area given its selection for the prepayment demo.

Diabetes is like chest pain — whether an admission is medically necessary depends on multiple factors and it’s not always clear when the patient is out of danger and ready to be sent home. Clinical markers, such as blood-glucose levels, may not tell the whole story, Wuebker says. Insulin-dependent diabetics whose blood-glucose levels are off the charts could develop DKA and land in the ICU, something that’s also happening more with noninsulin-dependent diabetics. If the clinical markers are normal in 24 hours, they may be sent home, which shows “you can’t rely on length of stay” to determine medical necessity, Wuebker says.

Other relevant factors include the patient’s age, the type of diabetes (insulin or non-insulin dependent) and comorbidities (e.g., lung or heart disease). “If it’s not treated properly, you get brain swelling and can die,” he says. “Just because the patient goes home in 24 hours doesn’t mean the patient is low risk.”

CMS’s embrace of prepayment reviews reflects its desire to determine if a claim is appropriate before paying rather than chasing the money after Medicare has paid the bill. It’s the kind of strategy used by the commercial insurance industry, which screens procedures and admissions before or as they occur, targeting high-dollar and/or borderline cases, he says. Prepayment reviews won’t accomplish quite the same thing because they still take place weeks or months after patients have left the hospital. But they cut the lag time of postpayment reviews.

Targets of MAC prepayment reviews are announced on each MAC’s website and hospitals should look there for a heads-up, Mills says. “We hope by catching [errors] upfront, it serves as an educational tool,” he notes.

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