

RAC... Now What

Valerie F. Barckhoff
Vice President, Revenue Cycle
QHR



**New Mexico Hospital
Association**

Greetings



Objectives



- Overview of RAC Program
- Current RAC Initiatives
- Moving Ahead of RAC

Overview of RAC Program

CMS RAC Review Phase-in Strategy

as of 06/24/09

Earliest possible dates for reviews in yellow/green states

- Automated Review- Black & White Issues (June 2009)
- DRG Validation- complex review (Aug/Sept 2009)
- Complex Review for coding errors (Aug/Sept 2009)
- DME Medical Necessity Reviews- complex review (Fiscal year 2010)
- Medical Necessity Reviews- complex review (calendar year 2010)

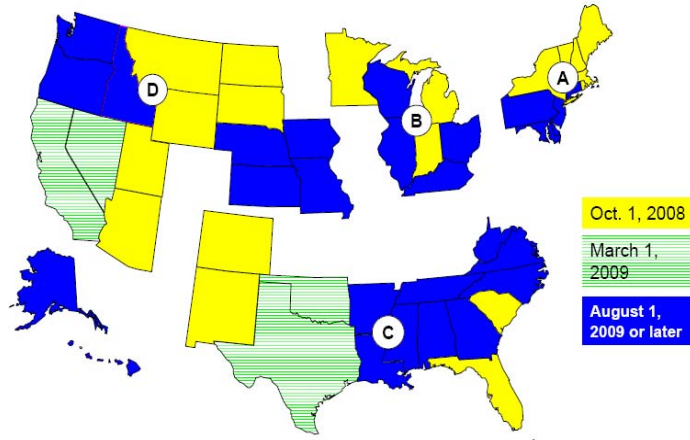
Earliest possible dates for reviews in blue states

- Automated Review- Black & White Issues (August 2009)
- DRG Validation- complex review (Oct/Nov 2009)
- Complex Review for coding errors (Oct/Nov 2009)
- DME Medical Necessity Reviews- complex review (Fiscal year 2010)
- Medical Necessity Reviews- complex review (calendar year 2010)

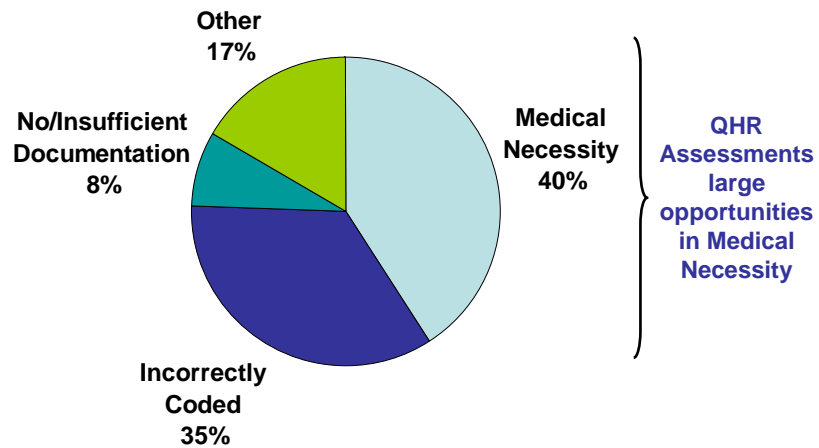
*Provider outreach must occur in the state prior to the beginning of any reviews

Phase In States

RAC Expansion Schedule



What We Know...



RACs Publish New Issues Approved by CMS.

CONNOLLY
healthcare

RAC Toll Free #:
866.360.2507

CMS RAC Program Provider Contact Information Contact Us Record Submission Approved Issues

www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

hdi

Home Region D Information Provider Information New Issues FAQ Contact Us

New Issues Approved by CMS

<http://racinfo.healthdatainsights.com/Public/NewIssues.aspx>

QHR | QUORUM
HEALTH RESOURCES

© 2009 Quorum Health Resources, LLC

The Audit Issues Affect:

- Physicians
- Hospital outpatients



QHR | QUORUM
HEALTH RESOURCES

© 2009 Quorum Health Resources, LLC

New Issues are Automated Reviews Performed from Claims Data

41 PREFIX	43 DESCRIPTION	44 HCPCS / RATE / ICD9 CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
390	Blood transfusion	36430	2/3/08	2			

Blood Transfusions

- CPT codes 36430, 36440, 36450 and 36455 (excluding claims with any modifiers) should be billed as one (1) per session, regardless of the number of units transfused on that date of service.
 - ◆ 36430 Transfusion, blood or blood components
 - ◆ 36440 Push transfusion, blood, 2 years or younger
 - ◆ 36450 Exchange transfusion, blood; newborn
 - ◆ 36455 Exchange transfusion, blood; other than newborn

Per Session or Per Day?

- Connolly – per session
- HDI – per date of service

231.8 - Billing for Transfusion Services

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

To report charges for transfusion services, OPSS providers should bill the appropriate CPT code for the specific transfusion service provided under Revenue Code 391 (Blood Administration). Transfusion services codes are billed on a per service basis, and not by the number of units of blood product transfused. For payment, a blood product HCPCS code is required when billing a transfusion service code. A transfusion APC will be paid to the OPSS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

www.cms.hhs.gov/manuals/downloads/clm104c04.pdf



© 2009 Quorum Health Resources, LLC

IV Hydration Therapy

- Based on the definition of CPT 90760 (excluding claims modifier 59), the maximum number of units should be one (1) per patient per date of service.
- Beginning, 1-1-09, code 90760 was replaced with code 96360



© 2009 Quorum Health Resources, LLC

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more one calendar day.

www.cms.hhs.gov/manuals/downloads/clm104c04.pdf



© 2009 Quorum Health Resources, LLC

Bronchoscopy Services

- CPT codes 31625, 31628 and 31629 should be billed with a maximum number of units of one (1) per patient per date of service (excluding claims with modifier 59)
 - ◆ 31625 Bronchoscopy with bronchial or endobronchial biopsy(s), single or multiple sites
 - ◆ 31628 Bronchoscopy with transbronchial lung biopsy(s), single lobe
 - ◆ 31629 Bronchoscopy with transbronchial needle aspiration biopsy(s), trachea, main stem, and/or lobar bronchus



© 2009 Quorum Health Resources, LLC

American Thoracic Society
We help the world breathe PULMONARY • CRITICAL CARE • SLEEP

About ATS Career Development Clinical Information Education Meetings & Courses Membership Publications Research

CAREER DEVELOPMENT BACKTO: Home > Career Development > Practitioner's Page > Practice Tips

Practice Tips

Bronchoscopy Coding 2005: An Update

Carol Pohlig, BSN, RN, CPC
 Senior Coding & Education Specialist
 Office of Clinical Documentation, Department of Medicine, Hospital of the University of Pennsylvania
 Philadelphia, PA

The manner in which you report bronchoscopy services remains unchanged (refer to "Practice Tips 2001: Troubleshooting Your Bronchoscopy Coding").

- Report multiple procedures performed during one session when appropriate.
- Append modifier -51, if required by your insurer.
- Consider the National Correct Coding Initiative edits (bundling versus mutually exclusive) when reporting code-pairs performed during one session.

Even though the basic coding principles are the same, over the last few years there have been several significant changes in the bronchoscopic codes recognized and reimbursed by insurers, providing for increased service capture and revenue opportunities.

CPT 2004
 The most awaited change in 2004 was the creation of codes identifying multiple biopsies performed during one bronchoscopy session. Although the bronchial/endobronchial biopsy (31625), regardless of the number performed, is still only reported once per session, physicians are now able to report transbronchial lung biopsies (31632) and transbronchial needle aspiration biopsies (31633) performed in each lobe beyond the original site. 31632 and 31633 are "add-on" services, which means they are never

www.thoracic.org/sections/career-development/practitioners-page/practice-tips/articles/tip25.html

QHR | QUORUM HEALTH RESOURCES

© 2009 Quorum Health Resources, LLC

Once in a Lifetime Procedures

- By virtue of the description of the CPT code, these codes can be performed only once per patient lifetime
 - ◆ https://www.cahabagballc.org/part_b/education_and_outreach/newsletters/2007/january/46.htm
 - ◆ http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/once_m00o03.doc
 - ◆ ??Amputation of forearm is on Cahaba list

Some Additional Codes to Look for Include:

- G0402 – G0405
Welcome to Medicare
exam/EKG
- G0389 AAA screening
- 90732 PPV vaccine



You Know Your Risk... Now What?

**RISK MITIGATION
STRATEGIES**



Example – MS-DRG 293

- Audit Results for MS-DRG 293
(Heart Failure & Shock w/o CC/MCC)
 - ◆ Focus Review on 0 and 1 day stays
 - Coding Accuracy - 97%
 - Medical Necessity Accuracy - 35%



Root Cause Analysis

- RCA Reveals
 - ◆ Only 70% of 0 and 1 day stays are being reviewed prior to discharge by Case Management
 - Issues related to:
 - ▶ Late Day Procedures
 - ▶ Weekend Admissions

Step 1: Controls in PFS

- It only becomes a problem when Medicare receives the claim!



- ◆ Based upon your assessment:
 - STOP the claims in you HIS or Billing System
 - ▶ Be specific – create an edit for Medicare DRG 293 with LOS = 0 or 1

Step 2 – Validate

- Most Case Management systems DO NOT interface with HIS or Billing Systems
 - ◆ Billers need validation that high risk accounts have been reviewed by Case Managers prior to releasing the claims
 - Two Solutions:



- ▶ Provide Billers access to CM System
- ▶ Require CMs to document in Core HIS System

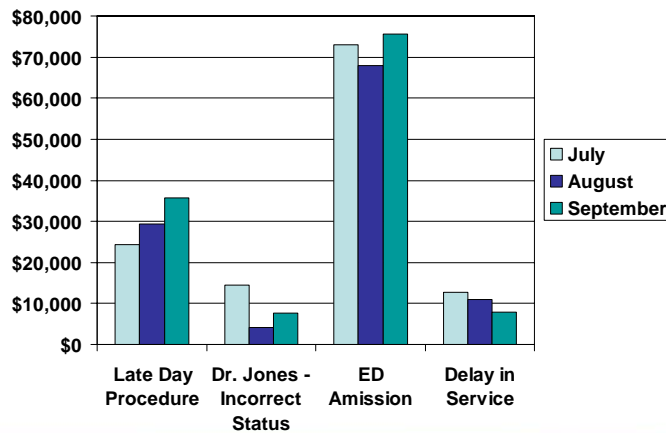
Step 3 – Bill Correctly

- If claim has not been reviewed:

- ◆ Return to Case Management for billing determination
 - If CM agrees with Billing Status
 - ▶ RELEASE CLAIM
 - If CM disagrees with Billing Status
 - ▶ Bill Part B services
(check with your compliance department for proper guidance)
 - ▶ Create NEW write-off code to track lost net revenue

Step 4 – Track and Trend

- Where is your process broken?



Step 5 – Concurrent Daily Reviews

- Medical Necessity Determination is not an easy task
 - ◆ Create and implement a “One Day Stay Team” that reviews high risk accounts the day after discharge
 - Proper Order?
 - CM correct determination of medical necessity?
 - Account okay to bill?

Step 6 - Scorecards

- Weekly and monthly scorecards will help monitor risk and success

Zero/One Day Stay Scorecard			
Metric	Actual	Target	
Claims reviewed within 1 business day	97%	100%	→
Med Nec Accuracy Rate	84%	97%	→
Accounts Approved by One Day Stay Team	90%	100%	→
Account Write Off (\$)	\$346,759	\$0	→
Next Steps:			
1. Conduct Case Management Interqual Training			
2. Provide Write-Off by Physician to UR Committee			

Then...Do It Again!



QHR | QUORUM
HEALTH RESOURCES

© 2009 Quorum Health Resources, LLC

Valerie F. Barckhoff

VP Revenue Cycle, QHR

Valerie_Barckhoff@QHR.com

404-918-1673

QHR | QUORUM
HEALTH RESOURCES