Secondary Payers Hit Physician Group with Recoupment After Medicare Audit Findings

A Medicare audit of a Kansas physician group is raising eyebrows because the audit findings were used by secondary payers to recoup their share of the purported overpayment. The secondary payers, which are commercial insurers that pick up the tab for expenses not covered by Medicare, have piggybacked on the Medicare administrative contractor’s (MAC) findings, according to an attorney for the physicians. Because the MAC extrapolated the error rate to a larger universe of claims, the recoupment from the different payers is packing a wallop.

“Their business office manager has a two-foot-high stack of secondary payer requests for repayment based on the MAC audit,” says Richelle Beckman, an attorney with the Forbes Law Group in Overland Park, Kan., which represents the physician group. As soon as the MAC completed the audit and identified overpayments, all the secondary payers requested their share before the physician practice even received the MAC’s demand letter or had a chance to appeal the denied claims, she says. If and when the physician practice wins its Medicare appeals, it will have to battle each secondary payer separately using whatever appeals process it has established.

Meanwhile, the physician group’s experience is a reminder that the use of extrapolation is spreading.

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Self-Disclosures: A Mixed Bag of Protection From Fines, Invitations for Whistleblowers

Voluntary self-disclosures offer salvation from the enormous fines and penalties that hospitals face if they are mired in an enforcement action. But there is a risk that during the process, employees may learn of the pending disclosure and use the information to file False Claims Act lawsuits against them, lawyers say. However, with the rise in national investigations, self-disclosure is an appealing route to head off the collateral damage of fraud allegations.

Hospitals take risks when they prepare to enter the OIG Self-Disclosure Protocol or the CMS Self-Referral Disclosure Protocol or they confess their sins to their U.S. attorney’s office, because any insider who gets wind of it can file a whistleblower lawsuit. “I see that as an underlying problem,” says one attorney, who asked not to be identified. For example, when health systems review their arrangements with physicians and realize there’s a Stark problem, they may send a preliminary letter to OIG or CMS saying they have identified a risk area and plan to make a disclosure when they complete their review. But when they tell the physicians it’s imperative to fix the noncompliant arrangements, the health systems may be creating whistleblowers, he says. “That problem is starting to crop up,” says the lawyer, who thinks even the Justice Department would admit this sabotages self-disclosure. “It is kind of frustrating for organizations that in-
certification requirement for outpatient occupational and physical therapy. Will the government really declare all the services performed by this small rural hospital unallowable, even though he says the therapy was necessary and actually provided? He shudders to think, but the regulations are clear enough that an analysis of self-disclosure was essential. In another case, an anesthesiologist tacked on five minutes to his anesthesiology services, which are time-based under Medicare. He helped the doctor return the money to the Medicare contractor. Repaying Medicare contractors can be a great way to reduce risk, he says.

“It is not a good case for the government anymore because you have taken the moral high ground. Every time you talked to them, you’d say, ‘we fixed it already.’ There’s no overpayment anymore,’” Fitzgerald says.

Contact Fitzgerald at jfitzgerald@polsinelli.com, MCDermott at kmcdermott@morganlewis.com and Richter at jrichter@kslaw.com.

Three Phrases Prompt Physicians To Document More Completely

When physicians document the level of amylase in a patient’s blood, they assume it’s understood that the high number means pancreatitis. But unless the numbers are translated into a diagnosis, hospitals are at a disadvantage with payers and auditors.

Reporting lab values without interpreting them is one of the documentation foibles that undermine the integrity of the medical record. “Communication between physicians is enhanced when the interpretation comes first and the supporting data second,” says cardiologist Jon Elion, M.D., an associate professor at Brown University and CEO of ChartWise Medical Systems. “Tell me what it means. It works well when making rounds and it works well on the chart.”

Hospitals have a lot riding on complete, accurate documentation — establishing medical necessity for procedures and admissions, coding MS-DRGs correctly and ensuring accurate severity of illness and mortality rates. But Elion sees physicians make the same mistakes again and again. There are, however, some simple phrases that prompt physicians to connect the documentation dots, Elion tells RMC. They help elicit the information needed to reduce errors and ensure resource utilization correlates to patient severity of illness and risk of mortality, which Medicare and private payers use to profile physicians and hospitals, he says.

CMS says that documentation should accomplish five goals, according to MLN Matters SE1027: “(1) Support the diagnosis, (2) Justify the treatment/procedures, (3) Document the course of care, (4) Identify treatment/diagnostic test results, and (5) Promote continuity of care among healthcare providers.” Hospitals may turn to clinical documentation improvement (CDI) programs to coax this information from physicians. But CDI programs threaten compliance if they are set up mostly to identify complications and comorbidities (CCs) and major CCs (MCCs), which increase MS-DRG reimbursement (see story, p. 5), Elion says. “If you are just after improved reimbursement, you will miss the chance for high-quality medical records,” he says. “But if the CDI is in pursuit of high-quality medical records, appropriate reimbursement will follow.”

There are some red flags. For example, be wary if a CDI consultant pledges in writing to increase hospital revenue and tells CDI specialists that their documentation-improvement job is done as soon as they identify an MCC. Also keep an eye on surges in certain MCCs, such as malignant hypertension, which accounts for only 1% of hypertension cases but generates about $3,000 more per case. The same goes for increases in Kwashiorkor, encephalopathy and sepsis, especially if they are MCCs in an expectedly high percentage of your cases.

CDI Programs Can ID Documentation Problems

When they are effective, CDI programs can identify cracks in the hospital’s documentation armor, Elion says. For example, physicians may describe problems without connecting them to diagnoses. Physicians may say “the patient has a cough, is producing sputum, has a fever and high white blood count and the chest X-ray shows an infiltrate” — but never use the word “pneumonia.” “Physicians would say, duh, their findings and recommendations are blatantly obvious. But the coder can’t code from that,” Elion says. “A well-intentioned coder will read the nurse’s note, which describes pneumonia and bedside teaching with the patient and family, and the radiologist’s note saying ‘right upper lobe infiltrate consistent with pneumonia.’ But the coder can’t code from those notes.” Similarly, the coder is stuck when the physician documents only that the patient was unable to urinate, so the physician inserted a catheter and found 500 ccs of urine. “Being unable to urinate is not something you can code but urinary retention is,” Elion says.

To get physicians to make what they often think are obvious connections between symptoms and diagnoses and to establish medical necessity for admissions or procedures, Elion suggests prompting them with certain phrases, including:  
◆ “Due to.” Suppose a patient comes to the hospital after passing out. He is very anemic, has bloody stools, and gets a blood transfusion, and the physician cauterizes the bleeding ulcer discovered in the patient’s stomach. But the chart never says “anemia is from the GI bleed.” Phys-
Physicians should connect the dots that “anemia is due to the GI bleed and the GI bleed is due to the peptic ulcer.”

◆ “Indications include.” Stating the indications is essential for establishing the medical necessity of a procedure or other treatment, especially when it comes to pricey cardiac conditions (e.g., congestive heart failure, arrhythmia, myocardial infarction). Surgeons have to establish, for example, why the patient needs a pacemaker, and noting his syncope and heart rate of 40 isn’t enough. “Maybe it’s medically correct, but there is not sufficient documentation for an indication of pacemaker. A lot of people are dizzy and have a low heart rate,” he says. “People have to do a better job of documenting clinical indicators — why you are doing something.” When there’s stenosis in the patient’s artery, “stentomaniacs” implant stents, Elion says, “but you have to be more spe-

### Review Sheet for Deciding Whether to Appeal Medical Necessity Denials

The review sheet below is a starting point to help hospitals decide when to appeal a claim denial. It was developed by Denise Wilson, director of training and education for Denial Research Group AppealMasters in Luthersville, Md. If hospitals can answer “yes” to any of the elements, they may have a persuasive appeal. “Of course, the decision to appeal is never black and white,” Wilson says. “You must still employ your own clinical education, expertise, and experience in your decision to appeal. There is both an art and science to writing a successful appeal.” Contact Wilson at dwilson@appealmasters.com.

### Justification of Medical Necessity of Setting of Care (inpatient versus outpatient) by CMS Guidelines

#### CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
- The severity of the signs and symptoms exhibited by the patient warrants possible need for inpatient admission.
- The medical predictability of something adverse happening to the patient warrants possible need for inpatient admission.
- The need for diagnostic studies warrants possible need for inpatient admission. The availability of diagnostic procedures at the time when and at the location where the patient presents warrants possible need for inpatient admission.
- This patient was expected to need hospital care for 24 hours or more.

#### CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.
- There are pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.
- The beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.

#### Inpatient Care is Supported by Evidence Based Guidelines
- Evidence Based Guidelines published by professional organizations (American College of Cardiology, American College of Emergency Physicians, etc.) or published medical literature, scientific data or research studies that have been published in peer-reviewed medical journals support inpatient admission or indicate the risk of an adverse event or poor outcome for this case.

#### Inpatient Only Procedures
- Procedure performed is on the CMS Inpatient Only list for the calendar year the procedure was performed. (Make sure the provider and CMS agree with the same procedural coding language.) ([http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html). Look for the final rule and download Addendum E for the Inpatient Only list.)

#### Outpatient Procedures in the Inpatient Setting
- A procedure routinely done in the outpatient setting, but the patient had pre-existing medical problems that required an inpatient setting. Contrast dye allergies or renal insufficiency, for example, that required additional pre-, peri-, and/or post-procedural interventions and/or monitoring. Pre-, peri-, or post-procedural complications that required an inpatient setting (not just prolonged observation time). A new symptomatic arrhythmia, for example. Consider whether the case meets any of the first six CMS guidelines listed above.

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Web addresses cited in this issue are live links in the PDF version, which is accessible at RMC's subscriber-only page at [http://aishealth.com/newsletters/reportonmedicarecompliance](http://aishealth.com/newsletters/reportonmedicarecompliance).
cific: “we documented ischemia and there was blockage in the anterior descending artery.”

“Manifested by.” This phrase helps ensure the completeness of the evidence that supports the stated conclusion, and may provide the coder with additional associated codable findings. For example, Elion says, “The patient has an altered mental status manifested by fluctuating degrees of severe confusion and disorientation” or “The patient presents to the emergency department with malignant hypertension, manifested by an acutely elevated blood pressure (220/140), edema of the optic disc, blurred vision, and acute kidney injury (creatinine has increased to 3.7 today from a baseline of 1.1 six days ago).”

These phrases “are very powerful in writing a note,” says Elion, who also spoke at a RACmonitor.com mini-webinar.

Documentation shortcuts in electronic health records also have their place, notwithstanding some recent Medicare claim denials (RMC 3/25/13, p. 1). Elion contends that copying and pasting notes from one record to another generally should be avoided. But there are two places it can be used safely and effectively: documenting the content of (1) the radiology report and (2) the pathology report. Since the coder can’t use these reports directly for coding because the radiologist and pathologist usually don’t have direct contact with the patient, their content needs to be directly stated in the clinical physician’s note. Physicians can say something like “I have personally reviewed the x-ray and its associated report from the radiologist. I agree with the findings as described by the radiologist, specifically <paste the radiology report here>.” Also, physicians have to avoid slang, no matter how colorful and descriptive. Even though “the ice cream fell off the cone” may perfectly capture what the orthopedic surgeon sees on the X-ray when patients have a slipped capital femoral epiphysis, it can’t be coded.

Elion suggests using real examples of flawed documentation from the hospital’s medical records as a teaching tool. Physicians are competitive and he has found they are more engaged in documentation improvement when presented with the opportunity to critique other physicians’ notes. Also, severity of illness and mortality data are coming into sharper focus. Medicare, for example, links payment to quality reporting and clinical processes in the value-based purchasing program and physician quality reporting system and reports the data on websites. Internally, hospital departments may compare physicians on patient complication rates, length of stay, utilization of services, morbidity/mortality, and costs and/or charges. Hospitals also take a big-picture look. For example, hospitals with a low length of stay and low mortality/morbidity rating but a high complication rate may question the discrepancy.

Contact Elion at jelion@chartwisemed.com.

Expand CDI Metrics Can Help Evaluate Quality as Well as MCCs

It’s a bad sign when clinical documentation improvement (CDI) specialists don’t bother to evaluate certain MS-DRGs because there’s no chance to leverage more reimbursement. CDI is about collaborating with clinicians to fill in the missing pieces of a patient’s medical picture, whether or not a particular case yields more revenue.

But that’s not always how it works, says Glenn Krauss, a manager for Accretive Health, who recently consulted at a hospital where the CDI specialist considered it a waste of time to review charts for MS-DRG 470 (major joint replacement) because there wouldn’t be an undiscovered MCC. If that’s the attitude, the hospital doesn’t have a meaningful CDI program, and opens itself up to claim denials for medically unnecessary admissions and services and MS-DRG coding that’s not supported in the medical records, Krauss says.

CDI specialists work with physicians and case managers to explain the progression of a patient’s illness and establish medical necessity. “The ideal program is to train health care providers to explain the progression of a patient’s illness and establish medical necessity.”

### Justification of Medical Necessity of Care or Procedure by CMS Guidelines

**CMS National Coverage Determination**

Medical necessity of the care provided or the procedure performed is defined within an NCD AND the documentation in the medical record supports all elements required by the NCD.

(VERY IMPORTANT: Does the NCD represent the current standard of care in the medical community for the year the care was provided or the procedure performed?)

**MAC Local Coverage Determination**

Medical necessity of the care provided or the procedure performed is defined within an LCD AND the documentation in the medical record supports all elements required by the LCD.

(VERY IMPORTANT: Does the LCD represent the current standard of care in the medical community for the year the care was provided or the procedure performed? Are there other LCDs outside of your MAC jurisdiction that support other standards of care?)