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CODING FOCUS NEWS

RACs

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CMS LISTS MORE THAN 14,000 MUEs
...AND COUNTING

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By Chuck Buck, Healthcare Information Specialist

THE RACs ARE BACK

The Recovery Audit Contractor program that has been put on hold since November 4, 2008, because of protests filed by two unsuccessful bidders for the RAC contract, is now poised to roll-out.

The automatic stay by the GAO, as required by the Competition and Contracting Act of 1984 (CICA), was resolved on February 4, 2009 when Viant Payment Systems, Inc. and PRG-Schultz USA, Inc., which were challenging the award by CMS of contracts under the RAC program, withdrew their protest.

According to CMS, the four RACs will contract with subcontractors to supplement their efforts. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C. Each sub-contractor has negotiated different responsibilities in each region, including some claim review.

The program was scheduled to begin last October with provider outreach services to those facilities in the 'first wave' states. Back in September, when things were moving forward as planned, Timothy Hill, CFO and Director Office of Financial Management, Centers for Medicare & Medicaid, spoke at a meeting of hospital executives in Washington and said that "the demand letters or requests for medical records for first round hospitals wouldn't be received until January 2009, noting that second round hospitals would receive theirs in March and third round hospitals in August."

Just 30 days earlier, CMS announced the selection of its permanent contractors. Those selected include the following:

- **Diversified Collection Services, Livermore, California, which would initially cover Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont;**
- **CGI Technologies and Solutions, Fairfax, Virginia, for Indiana, Michigan and Minnesota;**
- **Connolly Consulting Associates, Wilton, Connecticut, for Colorado, Florida, New Mexico and South Carolina; and**
- **HealthDataInsights, Las Vegas, for Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.**

Additional states would be added to each RAC region in 2009, according to the CMS.

First Wave States

CMS has divided the U.S. into four regions – A, B, C and D. First wave states include the following in each of these regions:

Region A	**Region B**
Maine	Indiana
Massachusetts	Michigan
New Hampshire	Minnesota
New York	
Rhode Island	
Vermont	

Region C	**Region D**
Colorado	Montana
Florida	Utah
New Mexico	Wyoming
South Carolina	

Show Me the Money

In addition to naming its permanent contractors, CMS also posted to its Website the contingency fee percentage from provider overpayments in each region, saying that the contingency fee was established during contract negotiations between the agency and each RAC. RACs are paid on "contingency" based on the amount of improper payments they correct for both overpayments and under-payments.

Region	Fee
Region A	12.45%
Region B	12.5%
Region C	9%
Region D	9.49%

CMS also exposed a Medicare error rate in 2007 of 3.8 percent that was equivalent to $10.8 billion in improper payments.

Medicare Improper Payments by Provider Type[1]

Provider Type	%
Outpatient Hospital/IRF/SNF/ Hospice/Home Health	12%
Physician/Ambulance/Lab/Other	33%
DME	10%
Inpatient Hospital	46%

Medicare Improper Payment by Error Type

Error Type	%
Incorrectly Coded	38%
Medically Unnecessary	33%
No/Insufficient Documentation	25%
Other	5%

By the end of the demonstration, RACs had collected $890 million in overpayments to providers.

Overpayments Collected by Provider Type

Provider Type	%
Outpatient Hospital/IRF/SNF/ Hospice/Home Health	4%
Physician/Ambulance/Lab/Other	1.5%
DME	1%
Inpatient Hospital	84%

Overpayments Collected by Error Type

Error Type	%
Incorrectly Coded	35%
Medically Unnecessary	40%
No/Insufficient Documentation	8%
Other	17%

Claims Overturned on Appeals Low

In early January, CMS issued "Update to the Evaluation of the 3-Year Demonstration." Of the nearly 25 percent of appeals filed by providers during the RAC demonstration, only 7.6 percent were overturned on appeal.

The updated information – primarily on Claim RACs – revealed that providers chose to appeal 22.5 percent of the RAC determinations and that of all the RAC overpayment determinations, only 7.6 percent were overturned on appeals. The information updates the Evaluation of the 3-Year Demonstration report released in July 2008 that included data through the end of the demonstration on March 27, 2008.

CMS reported that, overall, the updated data indicated that of all the RAC overpayment determinations (525,133), only 7.6 percent (40,115) were overturned on appeals as of August 31, 2008.

(Continued on page 5)

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By Susan Cinquino, CPC

MUEs – MEDICALLY UNLIKELY EDITS

Unlikable or Unbelievable CMS Publishes Combined Total of More Than 14,000

Effective January 1, 2009, the Centers for Medicare and Medicaid Services (CMS) released two files. One for hospital outpatient services (5,987) and the other for physician and other practitioner services (8,425) that combined together reach up more than 14,000 edits. Although there is some duplication that crosses over, it remains clear that the published edits continue to increase. On October 1, 2008, an approximate total of 8,100 MUEs were published and at that time according to CMS they stated that they would not release MUE values that were assigned four units or higher. Due to concerns of potential fraud and abuse that could result from disclosure of certain MUEs with lower values and those that CMS believed to be particularly vulnerable would also not be published. CMS has kept their word and released additional edits since then.

It is the belief that the MUE program will reduce costly payment errors and improve accuracy of claims payments. Taken from the CMS Website and quoted by a CMS administrator is the statement, "It is always our aim to ensure that CMS pays for appropriate services, at the same time protecting the Medicare Trust funds and the American taxpayer." The purpose of the MUE initiative is to improve the accuracy of Medicare payments by detecting and denying unlikely Medicare claims on a pre-payment basis.

BACKGROUND

In an ongoing effort to stop inappropriate payments, CMS initiated the MUE system in 2006. Official implementation began January 1, 2007. The National Correct Coding Initiative (NCCI) contractor assisted with the development of and maintains the MUE values. A MUE is defined as an edit that checks the number of times a service is reported by a provider or supplier, on line-by-line claims for the same patient on the same date of service. The edits examine the reported Health Care Common Procedure System (HCPCS)/ Current Procedural Terminology (CPT) code against an established number of units of service that are provided. Although the system was designed to reduce payment errors for Medicare Part B claims, currently the provider types affected are physicians, suppliers, and providers who bill Medicare Fiscal Intermediaries (FIs), Local Carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative contractors (DME/MACs), and/or Regional Home Health Intermediaries (RHHIs).

Originally, the MUE initiative was referred to as the "Medically Unbelievable Edits" project. After a fair amount of push back from the medical community and as a way to better reflect the purpose of the effort, CMS renamed the project to what we know today as "Medically Unlikely Edits."

In beginning stages of the initiative, CMS said they would not release the criteria for MUEs because physicians could use that knowledge to defraud Medicare by billing for more services than required or provided. It soon became clear that the public release of MUEs would be consistent with other CMS policies and this position contradicted the CMS historic commitment to transparency. Since 2007, the number of publicly disclosed edits increased from 2,600 to the 2009 latest version of the two combined files.

DENIAL AND APPEAL PROCESS

All MUEs are set to automatically trigger a denial for line items that have units of service that are billed greater than the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed MUE criteria. The general rule is if a denial is received, CMS states that it may be appealed. For those instances that the claim is not denied, but instead returned, the direction is to resubmit the claim. It is most wise, however, to refer to your local contractor for explicit instructions.

MUE values are not utilization guidelines and according to CMS, even if less than or equal to the MUE values are reported, providers may still be subjected to review of their claims by claims processing contractors. Medically reasonable and necessary services that exceed MUE values, such as repeat services that are performed at a different patient encounter on the same date of service, should be reported as two separate line items with the same HCPCS/CPT code and appropriate modifier.

A better example is the service that is repeated on the same day would be reported on one line with the applicable HCPCS/CPT code and again on a second line with modifier 76 (repeat procedure or service by same physician) or modifier 77 (repeat procedure by another physician). Correct coding with applicable modifiers, therefore is most critical to assure proper reimbursement.

Should a provider or supplier believe that a MUE value should be considered for modification, the process designated by CMS is to submit in writing the rationale for consideration along with the supporting documentation. The CMS Website provides further instructions and contact information that can guide you through the process.

CONCLUSION

Most MUEs assigned units 1-3 can be viewed from the CMS files provided on the CMS Website. There are two separate files, one for Practitioner/DME Suppliers and the other that contains the edit values for Hospital Outpatient Services. Both contain two columns, the first displays the HCPCS/CPT code and the second column shows the applicable MUE unit value.

Although CMS has not yet published whether there has been a determined savings as a result from the MUE program, it appears to be clear that the program will continue to expand.

Additional information regarding MUEs, including Frequently Asked Questions (FAQs), can be located on the CMS Website at www.cms.hhs.gov/NationalCorrectCodInitEd. Select "Medically Unlikely Edits" on the upper-left side of the page. ■

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CONTRACTOR	PROCESSING & DENIAL	APPEAL
Fiscal intermediaries (FIs) and Part A/Part B Medicare Administrative Contractors (A/B MACs)	Processing claims with the Fiscal Intermediary Shared System (FISS), return to provider claims with units of service exceeding the MUE value for the HCPCS/CPT code on the claim line.	The claim line is not denied. Therefore, no appeal process exists for MUEs for claims processed by Medicare's Fiscal Intermediary Shared System (FISS).
Carriers and A/B MACs	Processing claims with the Medicare Claims System (MCS) deny the entire claim line if the units of service on the claim line exceed the MUE value for the HCPCS/CPT code on the claim line.	Since claim lines are denied, the denial may be appealed.
DME MACs	Processing claims with the Medicare DME System (VMS) deny the entire claim line if the units of service on the claim line exceed the MUE value for the HCPCS/CPT code on the claim line.	Since claim lines are denied, the denial may be appealed.

CMS Announces Plans To Bolster Quality Of Care In Hospital Outpatient Departments

The Centers for Medicare & Medicaid Services (CMS) says it plans to strengthen the tie between the quality of care furnished to people with Medicare in hospital outpatient departments (HOPDs) and the payments hospitals receive for those services.

The final Outpatient Prospective Payment System/ Ambulatory Surgical Center Payment System (OPPS/ASC) rule also includes a 3.6 percent annual inflation update for HOPDs; and adopts changes to payment policies for HOPDs and Ambulatory Surgical Centers (ASCs) beginning on January 1, 2009. The law sets the ASC update for CY 2009 at 0 percent.

According to CMS, the final rule emphasizes that an "urgent and compelling rationale exists for CMS to exercise its existing administrative authority under the Medicare statute to develop and implement a policy that would not pay hospitals for care related to illness or injuries acquired by the patient during a hospital outpatient encounter." Such a policy, which CMS expects to propose in the future, would be known as hospital outpatient healthcare-associated conditions (HOP-HACs), and it would make adjustments to OPPS payments to ensure equitable and appropriate payment for care, similar to the quality adjustments applied to payment for hospital-acquired conditions in the inpatient setting.

Conditions of Coverage

The rule also establishes new conditions for coverage (CfCs) for Ambulatory Service Centers (ASCs) that reflect current ASC practice by focusing on the care provided to patients and the impact of that care on patient outcomes. CMS says these will help ensure ASCs are safely equipped and qualified to perform a much broader range of services under the revised ASC payment system, which was implemented on January 1, 2008, and will be in its second year of a four-year transition in the coming year. The new ASC CfCs will help improve assurance of the quality and safety of the care patients receive in ASCs.

ASC: New Definition

The new CfCs define an ASC as a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The proposed rule would have provided that the patient's treatment was not expected to require an overnight stay, defined as requiring active monitoring by qualified medical personnel, regardless of whether it is provided in the ASC, after 11:59 p.m. on the day of admission.

Projected Payments: $30.1 Billion

The changes in the final rule will apply to outpatient services furnished by more than 4,000 HOPDs in general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, community mental health centers, children's hospitals and cancer hospitals.

CMS projects that hospitals will receive $30.1 billion in CY 2009 for outpatient services furnished to Medicare beneficiaries, up from $28.5 billion in projected payments for CY 2008. Furthermore, CMS expects to make payments of almost $3.9 billion in CY 2009 to more than 5,100 ASCs that participate in Medicare, compared with $3.5 billion projected for CY 2008.

New Quality Measures

The Medicare law now requires that the annual OPPS payment inflation update be reduced by 2 percentage points for certain hospitals that do not meet quality reporting requirements. The final rule adopts four new quality measures for imaging efficiency, increasing the number of quality measures that HOPDs must report in CY 2009 to receive the full update in CY 2010 from the current 7 measures to 11. CMS will continue to consider for future years 18 additional quality measures in areas ranging from screening for fall risk to cancer care that were identified in the CY 2009 proposed rule, as well as other quality and efficiency measures as appropriate.

CMS is also changing how it pays for imaging services when two or more imaging procedures from an imaging family are provided in one session to encourage greater imaging efficiency. The final rule creates five imaging composite APCs (such as multiple computed tomography (CT) procedures) performed in a single hospital session. The change will apply to certain ultrasound procedures, CT and computed tomographic angiography (CTA) scans with or without contrast, and magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) scans with or without contrast.

The Transition

Under the final rule, the amount beneficiaries will pay for outpatient services will continue to decline based on a formula in the Medicare law that is designed to provide a gradual transition to 20 percent coinsurance for all APCs.

Prior to implementing the OPPS in CY 2000, beneficiaries were responsible for 20 percent of the hospital's charges, rather than 20 percent of the Medicare payment rate, for outpatient services. Because hospital charges rose faster over time than Medicare payment rates for these services, the beneficiary share often exceeded 50 percent of the total amount collected by the hospital for the service.

CMS estimates that nearly 25 percent of all types of services furnished in HOPDs, reflecting 85 percent of all billed services, will be subject to the 20 percent coinsurance rate in CY 2009.

For more information on the CY 2009 final rule with comment period for the OPPS and ASC payment system, please see the CMS Website at: http://www.cms.hhs.gov/HospitalOutpatientPPS. ■

Physician Payment Rule Implements New Electronic Prescribing Incentive Program

Physicians will be encouraged this year to trade in their prescription pads and improve efficiency and safety when ordering drugs for patients with Medicare.

The initiative is included in the Medicare Physician Fee Schedule (MPFS) final rule for calendar year 2009, according to CMS which says widespread adoption of electronic prescribing can eliminate medication errors that result from the misreading of handwritten prescriptions. Medicare beneficiaries may also have reduced out-of-pocket costs as e-prescribing facilitates communication between prescribers and pharmacies on lower-cost generic alternatives.

Incentives

CMS says that physicians and other eligible professionals who adopt and use qualified electronic prescribing (e-prescribing) systems to transmit prescriptions to pharmacies may earn an incentive payment of 2 percent of their total Medicare allowed charges during 2009. This incentive is in addition to a 2 percent incentive payment for 2009 for physicians who successfully report measures under the Physician Quality Reporting Initiative (PQRI), and both incentive payments are in addition to the 1.1 percent fee schedule update required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Thus, according to CMS, a physician who successfully reports under both the e-prescribing and PQRI initiatives could receive up to a 5.1 percent pay boost for 2009.

According to CMS, in order to participate in the e-prescribing incentive program, physicians will need to have a qualified e-prescribing system with certain required capabilities. The e-prescribing incentive program is one of several provisions intended to promote access to higher quality and more efficient health care that is included in a final regulation updating the MPFS, which establishes payment rates for more than 7,000 types of services based on the resources required to furnish them. The rates and policies adopted in the final rule will apply to services furnished on or after January 1, 2009.

Approximately 980,000 physicians and non-physician practitioners (NPPs) bill Medicare under the MPFS for the services they furnish to beneficiaries. Of these, nearly 95 percent accept Medicare's fee schedule rate as payment in full for their services. Medicare pays 80 percent of the fee schedule rate, while the beneficiary is responsible for the remaining 20 percent.

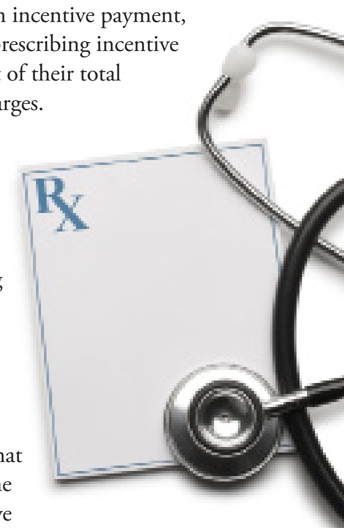
Payments to Physicians Increase

As required by MIPPA, which became law on July 15, 2008, payment rates for physician fee schedule services will be increased by 1.1 percent in 2009, rather than being reduced by 5.4 percent as would have happened if CMS had applied the physician fee schedule conversion factor projected in the proposed rule.

Total Medicare spending under the 2009 Physician Fee Schedule is projected at $61.9 billion, up 4 percent from the $59.5 billion projected for 2008.

Physician Quality Reporting Initiative (PQRI)

In the final rule, CMS also adopts improvements to the Physician Quality Reporting Initiative (PQRI), which allows eligible professionals to report quality measures relating to their clinical practice. Physicians who successfully report on their cases during 2009 will be able to earn an incentive payment, in addition to the e-prescribing incentive payment of 2 percent of their total Medicare allowed charges.



PQRI was expanded in July 2008 to provide alternative, streamlined methods for reporting. Among the changes for 2009 is removal of the quality measure 125 that was used to report on the use of e-prescribing, since that is now the focus of the e-prescribing incentive program.

New Quality Measures

The final rule also adds 52 new quality measures (bringing the total number of measures to 153 from which eligible professionals can select from for 2009 PQRI), addressing such areas as osteoarthritis, rheumatoid arthritis, back pain, coronary artery bypass graft (CABG), chronic kidney disease (CKD), melanoma, oncology, coronary artery disease, hepatitis, and HIV/AIDS. Eighteen of the new measures are reported exclusively through registries.

The revised policies and payment rates will become effective January 1, 2009. ■

RACs WILL BE BACK (CONTINUED FROM PAGE 2)

Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs Only

Item	Value
Claims with overpayment determinations	525,133
Claims appealed by provider (any level)	118,051
Claims with appeal decisions favorable to providers	40,115
Percentage of appealed claims with a decision in provider's favor	34%
Percentage of claims overturned on appeal	7.6%

Source: cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf

CMS said it would continue to update this information on a regular basis until all appeals have completed the appeals system.

Why They're Coming Back

Some industry experts believe that Congress sees the RAC program as saving the future of Medicare. If anything, the demonstration proved to be cost-effective for CMS. The total cost to run the RAC demonstration was $205.1 million. According to CMS Acting Administrator Kerry Weems, the program cost 20-cents for every dollar returned to Medicare.

Looking back, the three-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina and Arizona collected more than $900 million in overpayments with nearly $38 million in underpayments having been returned to healthcare providers.

The RACs succeeded in correcting more than $1.03 billion of Medicare improper payments. Approximately 96 percent of these improper payments were overpayments collected from providers, while the remaining 4 percent were underpayments repaid to providers.

Once asked by a newspaper reporter why he robbed banks, William "Willie" Sutton supposedly said, "because that's where the money is." ■

[1] *Timothy Hill, CFO and Director Office of Financial Management, Centers for Medicare & Medicaid, September 9, 2008.*