Complex Medical Necessity Reviews Underway: What Does the Past Tell Us?

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While recently approved medical necessity reviews in all four RAC regions suggest that increased RAC audit activity is imminent, providers should continue to address identified vulnerabilities in an effort to prevent additional RAC scrutiny. One place providers can look to distill key areas of vulnerability is the RAC Demonstration program, which began in 2005. CMS initially implemented the demonstration program in three states and later expanded it to include a total of six states in an effort to determine whether recovery auditing could be an effective tool for Medicare. As part of its RAC assessment, CMS collected improper payment information from the Demonstration RACs, including high risk medical necessity and coding vulnerabilities. CMS recently released three MLN Matters articles addressing several high risk vulnerabilities identified during the RAC Demonstration, which may prove helpful to providers as they prepare for increased audit activity under the RAC permanent program.

CMS released the first of three articles addressing high risk vulnerabilities in July 2010 (**SE1024**), which focused on documentation risk areas including the timely submission of medical record requests and insufficient documentation that failed to support that the services billed were covered, medically necessary or appropriately coded. For complex reviews such as DRGs and medical necessity, it is crucial that medical records requested be submitted for review in a timely manner. Failure to submit supporting medical documentation will surely result in claim denials.

Moreover, the documentation must be complete and legible. The medical records need to document the eligibility of the patient receiving treatment, that the Medicare criteria for coverage and billing requirements were met, and that the service was medically necessary and correctly coded. If the documentation fails to demonstrate the need for the service or that the appropriate level of care was provided, the claim will likely be denied on review.

Building on the insufficient documentation considerations set forth in the first MLN Matters article, CMS recently released the second (**SE1027**) and third (**SE1028**) articles in the series on September 23, 2010. These articles focused on specific high-risk vulnerabilities for inpatient hospital stays related to medical necessity reviews and DRG coding. With respect to medical necessity reviews, CMS listed 17 high risk vulnerabilities recognized in the RAC Demonstration Program, including Cardiac Defibrillator Implant (DRG 514/515), Heart Failure and Shock (DRG 127), Other Cardiac Pacemaker Implantation (DRG 116), and Chest Pain (DRG 143). CMS noted that while many of these services and procedures were deemed to be medically necessary, it was determined that they could have been performed in a less-intensive setting. More specifically, in order to avoid denials for inpatient admissions, the medical record must contain "sufficient documentation to demonstrate that the beneficiary's signs and/or symptoms were severe enough to warrant the need for inpatient medical care."

The Demonstration RACs also identified hospital coding vulnerabilities where the medical records submitted failed to support the codes billed. The high risk DRGs identified include: Respiratory System Diagnosis with Vent Support (CMS DRG 475), Closed Biopsy of Lung (CMS DRG 076, 077, 120), OR Procedure for Infections, Parasitic Diseases (CMS DRG 415), and Coagulopathy (CMS DRG 397/143). For inpatient admissions, the patient's principal diagnosis must be identified by the attending physician and CMS recommends documenting the principal diagnosis in both the medical record and discharge summary. "Other" or "secondary" diagnoses must also be provided by the attending physician for an inpatient admission.

The improper payment amounts associated with the high-risk claim types listed in the articles suggest that these claim types will also be the focus of the permanent RACs in the future. As such, it is extremely important for providers to improve their medical records so as to provide reviewers with a complete picture of the patient's medical condition to support the appropriateness of the code billed, and to eliminate claim denials for insufficient documentation. Hospitals and health systems need to stress to providers the impact of these "big ticket" denials and focus in on specific areas in the documentation of these services where additional information is needed.

Knowing what additional information the reviewers are looking for is half the battle. The MLN Matters articles touch on key documentation components providers can and should integrate. For example, providers should document pre-existing medical problems or other considerations that lead the provider to determine that inpatient admission was medically necessary. Developing documentation that indicates why the beneficiary's health would be threatened if care was provided in a less intensive setting is integral in supporting an inpatient level of care.

Likewise, when completing form-based progress notes, providers should ensure that all fields are completed, including fields that are not applicable to the specific patient to demonstrate that the criteria were considered in the evaluation. For example, a provider should enter "N/A" rather than leaving the field blank to indicate that the field was considered during the patient's assessment. Consistency among various portions of the medical record is also imperative. If contradictory information is noted, CMS recommends including documentation from the provider that explains the existence of the contradiction, if available. Proactive compliance focused on improving documentation efforts in these key areas of high-risk vulnerabilities can help providers avoid RAC claim denials on "big ticket" services and procedures in the future.

Links:

SE1024: https://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf

SE1027: http://www.cms.gov/MLNMattersArticles/downloads/SE1027.pdf

SE1028: http://www.cms.gov/MLNMattersArticles/downloads/SE1028.pdf