American Health Information Management Association

HEALTHCARE REIMBURSEMENT AUDIT TOOLKIT

AHIMA
American Health Information Management Association®

HEALTHCARE REIMBURSEMENT AUDIT TOOLKIT

ISBN: 978-1-58426-427-9
AHIMA Product No.: ONB187013
AHIMA Staff:
Jessica Block, MA, *Assistant Editor*
Jason Malley, *Director, Creative Content Development*
Anne Zender, *Editorial Director*

For more information about AHIMA Press publications, including updates, visit ahima.org/publications/updates.aspx

American Health Information Management Association
233 N. Michigan Ave., 21st Fl.
Chicago, IL 60601

FOREWORD

Compliance is a critical function within health information management (HIM) practices whether it is appropriate documentation, effective management of the documentation, or clinical coding and reimbursement. In the past, health record audits have existed to identify improper payments and prevent fraud and abuse; however, the scope and volume of these audits has greatly expanded to not only include governmental payers but external payers. Healthcare organizations must have an understanding of the different types of audit programs and entities engaging in audits. What's more, they must have established policies and procedures to appropriately manage incoming record requests and the associated denial and appeal processes.

This toolkit provides guidance to HIM professionals on the identification of the internal support team, development of policies and procedures, establishment of an educational program and management of record requests, denials, and appeals. The toolkit highlights several governmental entities and governmental programs that focus on medical record audits.

PREPARED BY

Cynthia Doyon, RHIA
Gail Garrett, RHIT
Linda Hyde, RHIA
Laurine Johnson, MS, RHIA, CPC-H
Shelley C. Safian, PhD, CCS-P
Donna Wilson, RHIA, CCS, CCDS, CPHM

ACKNOWLEDGEMENTS

Sue Bowman, MJ, RHIA, CCS, FAHIMA
Angela N. Dinh-Rose, MHA, RHIA, CHPS
Margaret M. Foley, PhD, RHIA, CCS
Yvette Gauthier, MBA/HCM, RHIA
Erin Head, MBA-HCM, RHIA
Deshawna Hill-Burns, RHIA
Sandra Huyck, RHIT, CCS-P, CPC, CPC-H
Pam Jacobsen, RHIT, CCS
Monna Nabers, MBA, RHIA
Theresa Rihanek, MHA, RHIA, CCS
Laura J. Rizzo, MHA, RHIA
Rayna Scott, MS, RHIA, CHDA
Diana Warner, MS, RHIA, CHPS, FAHIMA
Lou Ann Wiedemann, MS, RHIA, CPEHR, FAHIMA
Gail Woytek, RHIA

This toolkit is based on two previous AHIMA works: the Governmental Audit Toolkit and the Recovery Audit Contractors Toolkit. We would like to acknowledge the original authors and reviewers:

GOVERNMENTAL AUDIT TOOLKIT PREPARED BY

Dawson Ballard, CCS-P, CPC, CEMC
Cathy Brownfield, RHIA, CCS
Karen Cole, RHIT, CCS-P, RCC, CPC-H, GCGS
Sharon Easterling, MHA, RHIA
Mary Gregory, RHIT, CCS, CCS-P, CPC
Tedi Lojewski, RHIA, CCS
Pat Maccariella-Hafey, RHIA, CCS, CCS-P, CIRCC
Ginny Martin, RHIA, CCS
Kathy Myrick, RHIT, CCS
Donna Wilson, RHIA, CCS, CCDS, CPHM

ACKNOWLEDGEMENTS

Kathy DeVault, RHIA, CCS, CCS-P
Lou Ann Wiedemann, MS, RHIA, CPEHR, FAHIMA

RECOVERY AUDIT CONTRACTORS TOOLKIT PREPARED BY

Jill S. Clark, MBA, RHIA
Gail Garrett, RHIT
Sarah Hurst- student
Linda A. Hyde, RHIA
Laurie M. Johnson, MS, RHIA, CPC-H
Krystal M. Lloyd, RHIA, CCS
Anita Majerowicz, MS, RHIA
Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CPC-I, CHA
Donna Wilson, RHIA, CCS

ACKNOWLEDGEMENTS

Angela K. Dinh-Rose, MHA, RHIA
Cheryl Gregg Fahrenholz, RHIA, CCS-P
Margaret M. Foley, PhD, RHIA, CCS
Kathy Fox, RHIA, CCS, CCS-P, CHC
Wanda Johnson, RHIT
Jane M. Kelly, PhD, CPC
Faith Neal, RHIA, CCS, CHP, CPHQ, CPHRM, CSHA
Allison Viola, MBA, RHIA

TABLE OF CONTENTS

This toolkit supersedes AHIMA's "Governmental Audit Toolkit" (December 2011) and "Recovery Audit Contractor (RAC) Toolkit" (January 2010).

INTRODUCTION

The HIM professional should have a fundamental understanding of each of the governmental and other external audit programs currently in place. Terms such as CERT, DOJ, HEAT, MAC, MIC, OIG, RAC (Medicare & Medicaid,) and ZPICs are discussed in this toolkit.

Best practice guidance provided in this toolkit was developed for use across all organizations and for all providers. Therefore, the formats to handle external audits may vary depending on the role of the individual and the type of facility or healthcare organization.

CHART OF EXTERNAL AUDIT PROGRAMS AND GOVERNMENTAL AGENCIES

ACRONYM	MEANING	FUNCTION
CERT	Comprehensive Error Rate Testing	Calculates the national paid claims error rate for all Medicare fee for service claims paid by MACs
DOJ	Department of Justice	The U.S. attorneys' office under DOJ uses Health Care Fraud and Abuse Control (HCFAC) funds to support their work combating healthcare fraud and abuse. The HCFAC funds salaries for attorneys, auditors, and investigators and for litigation of the fraud cases.
HEAT	Health Care Fraud Prevention and Enforcement Action Team	Combined program between HHS and DOJ to fight Medicare fraud
MAC	Medicare Administrative Contractors	MACs are replacing carriers and fiscal intermediaries. They process Parts A & B claims, conduct medical reviews and other audits, and process RAC and APIC overpayment findings.
MEDICAID RAC	State Medicaid Recovery Audit Contractors	The Affordable Care Act requires states to contract with RACs by 12/31/2010 to identify underpayments and recoup overpayments in their Medicaid programs. States will be able to tailor the RAC activities to their unique Medicaid programs.
MFCU	Medicaid Fraud Control Units	MFCUs investigate and prosecute suspected provider fraud, often via referrals from state Medicaid agencies. 43 MFCUs are located in the states' offices of attorneys general. The other seven are housed within other state agencies.
MIC	Medicaid Integrity Contractors	MICs perform four key activities: 1) review provider actions; 2) audit claims; 3) identify overpayments; and 4) educate providers, managed care entities, beneficiaries, and others with respect to payment integrity and quality of care.
MIP	Medicaid Integrity Program	Created in 2006 to combat Medicaid fraud, waste and abuse by hiring contractors to review provider activities, audit claims, identify overpayments and educate providers. Also supports the states in their efforts to combat Medicaid fraud.
OIG	HHS Office of Inspector General	Conducts audits, investigations, evaluations and inspections; recommends corrective actions; refers suspected criminal action; and imposes sanctions
OMIG	State Offices of Medicaid Inspector General	Titles of these offices could vary by state, and only about a dozen states have one. They are often entities created by state statute to coordinate Medicaid program integrity control activities among state agencies. They work closely with MFCU and other state and federal officials.
PERM	Payment Error Rate Measurement Contractors	PERM contractors randomly select claims to audit in 17 states during a 23-month cycle to set the state's error rate. It reviews the fee-for-service, managed care, and eligibility components of Medicaid and the Children's Health Insurance Program
RAC	Medicare Recovery Audit Contractors	Review claims for improper payments made under Medicare Parts A & B. The health reform law extends RACs to Parts C & D.
RADV	Medicare Advantage Risk Adjusted Data Validation	CMS audit program for Medicare Advantage programs to ensure that risk-adjustment payments are supported by the medical record
ZPIC	Zone Program Integrity Contractors	Replaced program safeguard contractors (PSCs). They conduct fraud and abuse investigations of all types of claims in a geographic area.

GOVERNMENTAL BACKGROUND

Peer review organizations (PRO) were implemented in the 1980s and focused on many of the same issues that are being dealt with today. Those early audits demonstrated that correct coding and medical necessity were necessary to avoid future denials. The return on investment (ROI) even in the early days of governmental auditing proved to be lucrative and resulted in the addition of multiple governmental auditing programs and the creation of external auditing programs.

AUDIT PROCESS

WHO IS ELIGIBLE TO BE AUDITED

Governmental auditors are authorized to investigate claims submitted by physicians, providers, facilities, and suppliers. This essentially includes all organizations and providers that provide Medicare beneficiaries with procedures, services, and treatments, and submit claims to Medicare (and/or their fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B/MAC), durable medical equipment Medicare administrative contractors (DME MAC), and/or carriers). In addition, the Centers for Medicare and Medicaid Services (CMS) has mandated that individual states perform audits for Medicaid beneficiary claims submitted.

PREPARATION CHECKLIST

In preparing for governmental and external audits, it is important for each organization to recognize who needs to be involved in the process, and develop appropriate policies and procedures and education initiatives to support the program. Each organization must also be familiar with the different types of records requests and timeframes and distinguish the requirements for the various types of appeals to ensure the organization secures appropriate payment for each claim. The Preparation Checklist found in Appendix A provides an overview to help HIM professionals understand these action steps and provides references to key resources throughout the toolkit.

HIERARCHY OF AUTHORITY

It is important for an organization/physician practice to establish a hierarchy of authority that defines the role of all multidisciplinary team members associated with the management of these governmental and external audit programs. The resources provided in this toolkit represent all types of provider settings. A sample Hierarchy of Authority document can be found in Appendix B. This document can be tailored to fit organizational needs based on size and type.

In addition, the audit coordinator is an essential role in any program. The audit coordinator serves as the focal point for all audit activity, helping to manage and oversee the internal process. A sample job description of the audit coordinator can be found in Appendix C.

INTERNAL POLICIES AND PROCEDURES

It is critical for an organization to create and implement official organizational policies to ensure leadership support, clear communication, and systematic procedures based on the hierarchy of authority. Policies should identify all stakeholders and provide clear guidance for document submission for all governmental and external audits. It is important to remember external review agencies may have different review scopes and may require different documentation from the patient's encounter. It is also essential to ensure that processes are tailored to address these differences accordingly in order to avoid costly denials and the need to submit additional information. Keep in mind that processes vary by institution and may require alteration as organizational needs change (i.e., staff, budget, structure, etc.) For sample policies and procedures, see Appendix D.

EDUCATION

HIM professionals need to identify the appropriate staff who require education on the current status of any and all governmental and external audits, recognize the educational opportunities from CMS, and develop an internal training program accordingly.

Sample training material developed by the National Medicare Training Program can be accessed at:

- www.cms.gov/Outreach-and-Education/Training/NationalMedicareTrainingProgram/Training-Library-Items/CMS1248271.html

This training module identifies Medicare fraud and abuse and discusses Medicare and Medicaid fraud and abuse prevention, detection, reporting, and recovery strategies.

The Office of the Inspector General (OIG) also provides free training for healthcare providers, compliance professionals, and attorneys. The OIG's Provider Compliance Training was an outreach initiative developed as part of HHS's and the US Department of Justice's Health Care Fraud Prevention and Enforcement Action Team.

- Videos and audio podcasts: https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp
- Webcasts and presentation materials: https://oig.hhs.gov/compliance/provider-compliance-training/index.asp#webcast

For a sample outline on how to develop an education program, see Appendix E. For a sample audit training presentation, see Appendix F. For a listing of audit-related acronyms, see Appendix K.

GOVERNMENTAL AUDITS

CERT–COMPREHENSIVE ERROR RATE TESTING PROGRAM

Update prepared by Cynthia Doyon, RHIA; original prepared by Dawson Ballard CCS-P, CPC, CEMC

SCOPE OF WORK

The Comprehensive Error Rate Testing Program (CERT) was implemented by CMS for the purpose of measuring improper payments in the Medicare fee-for-service (FFS) program. The CERT Program was designed to comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

RECORD REQUESTS AND LIMITS

All claims for the CERT Program are randomly selected. The Improper Medicare Fee-For-Service Payments Report from 2011 outlines how records are requested for the CERT Program.

CURRENT ISSUES

Healthcare providers have 75 days to respond to the CERT Documentation Contractor paper requests for records. Multiple requests may be received during this time frame. The most common errors found by the two current contractors (CERT Review Contractor and CERT Documentation Contractor) are:

- Insufficient documentation
- Medical necessity
- Incorrect coding
- Other, such as duplicate payment, no benefit category, other billing errors

CONTACT INFORMATION/LINKS:

- CERT program: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html
- "Medicare Fee-for-Service 2011 Improper Payments Report": https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/2011-Medicare-FFS-Improper-Payment-Report-.pdf

Many of the Medicare Administrative Contractor (MAC) websites also provide detailed information about the CERT program:

- https://www.certprovider.com
- cgsmedicare.com/hhh/education/materials/CERT.html
- cgsmedicare.com/parta/cert/cert_letter_english.pdf

DOJ—DEPARTMENT OF JUSTICE

Prepared by Cathy Brownfield, RHIA, CCS

SCOPE OF WORK

The Department of Justice oversees many of the auditing agencies including OIG, RAC, ZPICs, and HEAT. Providers can still be audited by the DOJ outside of these other programs if a reason for concern is identified.

RECORD REQUESTS AND LIMITS

There are no record limits on DOJ requests.

CURRENT ISSUES

Various DOJ audits are occurring throughout the nation. Some of these audits include septicemia, records with one CC or MCC on the claim, and hospice medical necessity.

CONTACT INFORMATION/LINKS:

- justice.gov/
- justice.gov/oig/

HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM (HEAT)

Prepared by Donna Wilson, RHIA, CCS, CCDS, CPHM

In May 2009, the Department of Health and Human Services (HHS) and Department of Justice (DOJ) created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With its creation, the fight against Medicare fraud became a Cabinet-level priority. HEAT's work is directed by HHS Secretary Kathleen Sebelius and Attorney General Eric Holder.

SCOPE OF WORK

- To gather resources across the government to help prevent waste, fraud, and abuse in the Medicare and Medicaid programs
- To crack down on the people and organizations who abuse the system and cost Americans billions of dollars each year
- To reduce healthcare costs and improve quality of care by preventing fraudsters from preying on people with Medicare and Medicaid
- To highlight best practices by providers and organizations dedicated to ending waste, fraud, and abuse in Medicare
- To build upon the existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars[1]

RECORD REQUESTS AND LIMITS

There are no limits on record requests; the type of audit determines the limits.

CURRENT ISSUES

The joint DOJ-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state, and local investigators designed to fight Medicare fraud. The Force uses Medicare data analysis techniques and an increased focus on community policing to combat fraud.

The Medicare Fraud Strike Force has recently expanded to include nine cities: Baton Rouge, LA; Brooklyn, NY; Chicago, IL; Dallas, TX; Detroit, MI; Houston, TX; Los Angeles, CA; Miami–Dade, FL; and Tampa Bay, FL.[2]

CONTACT INFORMATION/LINKS:

HEAT by state: stopmedicarefraud.gov/newsroom/your-state/index.html

MAC—MEDICARE ADMINISTRATIVE CONTRACTORS

Update prepared by Gail Garrett, RHIT; original prepared by Ginny Martin, RHIA, CCS, and Mary Gregory, RHIT, CCS, CCS-P, CPC

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated that the previous Medicare contractors for the Part A and Part B Fee-for-Service (FFS) programs be replaced with new contractors called Medicare Administrative Contactors (MACs). MACs are responsible for processing the claims for Medicare Part A and Part B FFS. MACs replaced the previous Medicare fiscal intermediaries and carriers. Unlike fiscal intermediary and carrier contracts, MAC contracts will be competitively and openly bid upon and awarded. CMS anticipates that competitively bid contracts will create a more effective and efficient Medicare program. CMS will put the contracts up for bidding at least once every five years.

SCOPE OF WORK

The responsibility of the MAC is to process claims submitted by physicians, hospitals, and other healthcare providers/suppliers and submit payment to those providers in accordance with Medicare rules and regulations. This includes identifying and correcting underpayments and overpayments.

Per the Medicare Administrative Contractor (MAC) Jurisdiction Fact Sheet dated July 2010, the goals of the MAC are to achieve the following improvement of services to the beneficiary and providers:

- **Improved Beneficiary Services**
  - Most beneficiaries can have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize.
  - A/B MACs are required to develop an integrated and consistent approach to medical coverage across service area, which benefits both beneficiaries and providers.
  - Beneficiaries can have their questions on claims answered by calling 1-800-MEDICARE, their single point of contact.
- **Improved Provider Services**
  - A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers.
  - Competition will encourage MACs to deliver better services to providers.
  - Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.[3]

CMS established the MACs' jurisdictions to accomplish the following:

- Balance allocation of workloads
- Promote competition
- Account for integration of claims processing activities
- Mitigate the risk to the Medicare program during the transition to the new contractors.

The result is jurisdictions that reasonably balance the number of Fee-for-Service beneficiaries and providers. While these jurisdictions exhibit some variation in size and workload, they are more equalized than the existing fiscal intermediary and carrier workload.[4]

By centralizing both hospital and physician claims, CMS will have a more comprehensive look at the overall healthcare services provided to Medicare beneficiaries. CMS believes this will improve beneficiary and provider services associated with the consolidation. This consolidation provides CMS with a comprehensive database of services to more effectively target provider audits, analyze episodes of care, and link services across provider types.

In addition to processing claims, MACs have been given the responsibility to analyze Medicare claims to determine compliance with coverage, coding, and billing rules. This is typically performed through a medical record review, which can be performed on either a pre-payment or a post-payment basis.

CURRENT ISSUES:

Pre-payment Review

MACs conduct pre-payment reviews of Medicare claims to identify potential payment errors prior to processing the claim. These pre-payment reviews must follow Medicare's Medical Review guidelines.

Pre-payment reviews can be performed as probe samples, which involve randomly requesting between 20 and 40 inpatient or outpatient service records. Besides randomly selecting claims on a prepay basis, MACs may also target providers for specific reasons. MACs utilize data-mining technology to search for trends and noticeable irregularities.

It is important to note that if problems are found with the Part A claims during the pre-payment review, payment will be denied, and the MAC may then perform a post-payment audit of the Part B physician services claims related to the problematic claims.

Some of the most common MS-DRGs currently subject to review are listed below. However, these can vary by MAC, so it is important to regularly visit the contractor's website for updates.

Common MS-DRGs

069 – Transient ischemia
226 – Cardiac defibrillator implant w/o cardiac catheter w/major complications or comorbitities (MCC)
227 – Cardiac defibrillator implant w/o cardiac catheter w/o MCC
242 – Permanent cardiac pacemaker implant w/MCC
243 – Permanent cardiac pacemaker implant w/CC
244 – Permanent cardiac pacemaker implant w/o CC or MCC
247 – Percutaneous cardiovascular procedure w/drug eluting stent w/o MCC
251 – Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC
253 – Other vascular procedures w/CC
287 – Circulatory disorders except acute myocardial infarction (AMI), w/cardiac catheter w/o MCC
291 – Heart Failure and Shock w/MCC
292 – Heart Failure and Shock w/CC
293 – Heart Failure and shock w/o CC or MCC
313 – Chest pain
392 – Esophagitis, gastroenteritis, and miscellaneous digestive w/o MCC
460 – Spinal fusion except cervical w/o MCC
470 – Major joint replacement or reattachment of lower extremity w/o MCC
552 – Medical back problems w/o MCC
641 – Nutritional miscellaneous metabolic disorder w/o MCC

Post-payment Review

Similar to other external review agencies, MACs also review claims retrospectively (meaning post-pay) for indications of improper payments. Post-payment reviews consist of a medical record review of a claim after payment. This review is commonly performed using a statistically valid methodology for sampling. Sampling allows estimation of an underpayment or overpayment without requesting all records.

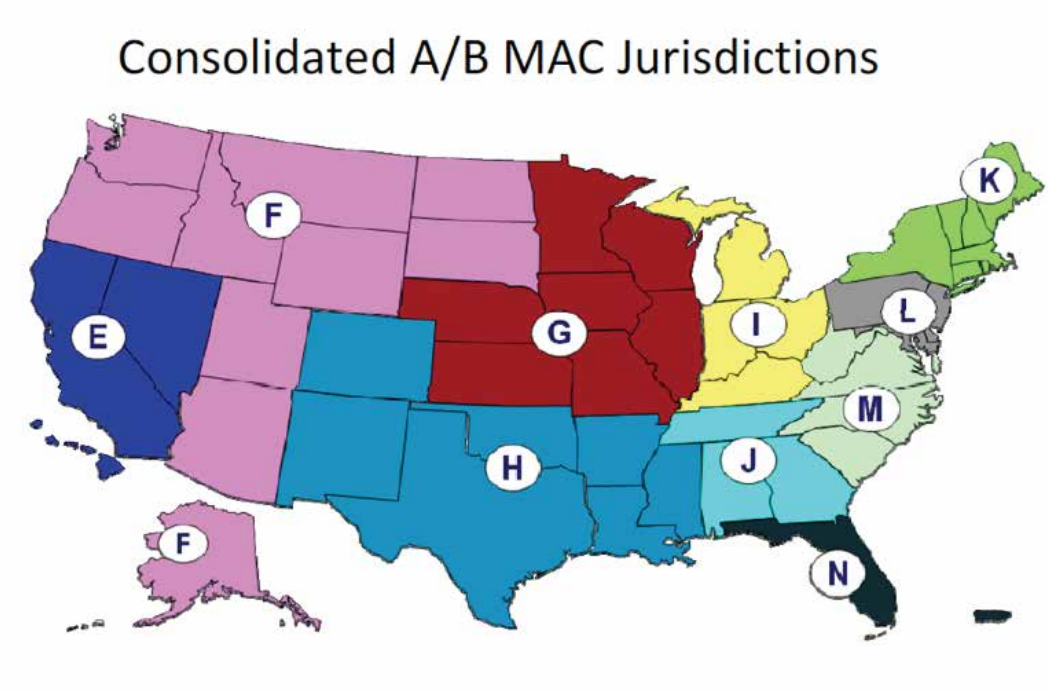
CONTACT INFORMATION/LINKS:

Medicare Contracting Reform: cms.gov/Medicare/Medicare-Contracting/MedicareContracting Reform/index.html

CURRENT MACS

Appendix G contains a table which lists the current MAC for each state. This table is organized by state alphabetically for quick reference. For each state, the MAC Part A, MAC Part B, and a corresponding link to a website are identified. In locations that the Part A and Part B have been consolidated into a combined Part A/B MAC, the same contractor will be listed in both columns. In the event, there is more than one Part A MAC listed for a state, consult the provided link and/or check with your billing department to determine the organization's MAC. This is especially true if your organization is part of a larger healthcare system.

CMS awards contracts for the administration for Medicare Part A and Part B claims in a jurisdiction to a specific contractor(s). As this is an ongoing process, specific information related to awarding of certain jurisdictions, protest updates, and implementation updates, consult the following CMS website: cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Spotlight.html.



The map above illustrates the consolidated A/B MAC jurisdictions.[5]

MEDICAID (MIC/MIP, MEDICAID RAC, PERM)

Update prepared by Donna D. Wilson, RHIA, CCS, CCDS, CPHM; Original prepared by Tedi Lojewski, RHIA, CCS

MEDICAID INTEGRITY PROGRAM GENERAL INFORMATION

In February 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law and created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act (the Act). The MIP is the first comprehensive federal strategy to prevent and reduce provider fraud, waste, and abuse in the $300 billion per year Medicaid program.

SCOPE OF WORK

The program's purpose is to hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. These auditors are known as MICs (Medicaid Integrity Contractors). The program also aims to provide effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse.

Along with these responsibilities, section 1936 of the Act requires that CMS develop a five-year Comprehensive Medicaid Integrity Plan in consultation with internal and external partners. CMS is also required to report to Congress annually on the effectiveness of the use of funds appropriated for the MIP.

Although the states are primarily responsible for the Medicaid program, CMS provides technical assistance, guidance, and oversight in the efforts to combat fraud and abuse. Fraud schemes often cross state lines, and CMS strives to improve information sharing among the Medicaid programs and other stakeholders.

RECORD REQUESTS AND LIMITS

Providers have 30 business days to respond to document requests. Providers may request an additional 15 days extension if justified.

CURRENT ISSUES

States have begun to self-report program integrity practices that they believe to be effective and demonstrate their commitment to program integrity, such as:

1. Iowa sends annual letters to providers reminding them of the prohibition against hiring and contracting with excluded parties and reminding providers of the consequences of non-compliance.
2. Massachusetts extended exclusion checking to individuals providing services through waiver programs.
3. New York and Ohio maintain web-based exclusion databases and run provider applications against this file.
4. Alaska, New Jersey, and Texas have staff dedicated to conducting background checks on certain Medicaid providers as part of the enrollment process.
5. Connecticut's provider applicants are required to answer all questions on the Provider Enrollment Disclosure Questionnaire prior to being considered for enrollment.

CONTACT INFORMATION/LINKS:

- Deficit Reduction Act: cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct
- Medicaid Integrity Program: cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html
- How to report fraud: medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

The following table provides information regarding the Medicaid Integrity Program by Topic. [6]

Name	Description
Comprehensive Medicaid Integrity Plan (CMIP)	The CMIP is developed in consultation with key stakeholders and details the Medicaid Integrity Program's five-year comprehensive strategy for combating fraud, waste, and abuse.
Report to Congress	An annual report to Congress on the use and effectiveness of the funds appropriated for the Medicaid Integrity Program
Provider Audits	Section 1936 of the Social Security Act obligates the CMS to procure contractors to audit Medicaid claims and identify overpayments. To fulfill this statutory requirement, the Medicaid Integrity Program (MIP) has procured Audit Medicaid Integrity Contractors (Audit MICs) to conduct provider audits throughout the country.
Medicaid Guidance Fraud Prevention	Best practices and performance standards for states to use in their fraud prevention efforts
State Program Integrity Reviews	Through these triennial reviews, CMS assesses the effectiveness of the state's program integrity efforts, including its compliance with federal statutory and regulatory requirements. The reviews also assist in identifying effective state program integrity activities which may be considered particularly noteworthy and shared with other states.
Medicaid Integrity Institute (MII)	The mission of the MII is to provide effective training, tailored to meet the ongoing needs of state Medicaid program integrity employees, with the goal of raising national program integrity performance standards and professionalism.
State Program Integrity Assessment (SPIA)	The State Program Integrity Assessment (SPIA) is the CMS's first national data collection on state Medicaid program integrity activities for the purposes of program evaluation and technical assistance support. CMS will use the data from the SPIA to develop descriptive reports for each state, identify areas to provide states with technical support and assistance, and assess states' performance over time.
Tamper-Resistant Prescriptions	All written prescriptions for outpatient drugs prescribed to a Medicaid beneficiary must be on paper that meets all three baseline characteristics of tamper-resistant pads.
Program Integrity Review Report List	Comprehensive state program integrity (PI) review reports (and respective follow-up review reports) provide CMS' assessment of the effectiveness of the state's PI efforts, including its compliance with federal statutory and regulatory requirements. They also assist in identifying effective state PI activities which may be noteworthy and shared with other states. Focused PI review reports provide information on reviews conducted to examine specific areas of PI concern in one or more states.

MEDICAID RACS

Prepared by Donna D. Wilson, RHIA, CCS, CCDS

The success of the Medicare RACs resulted in the inclusion of Section 6411 of the Affordable Care Act (ACA), which expands the current RAC program to Medicaid and Medicare Parts C and D.

SCOPE OF WORK

The legislation calls for states to:

- Contract with RACs in order to identify overpayments and underpayments by the state Medicaid agency, and to recoup overpayments
- Create processes for entities to appeal adverse determinations made by RACs
- Coordinate recovery efforts with other governmental entities performing audits, including federal and state law enforcement agencies such as the FBI, HHS, and the state Medicaid Fraud Control Unit

CURRENT ISSUES

As of January 1, 2012, all states were to implement a Medicaid RAC program. Below are some examples of states' progress:

1. Arizona is a participant in a statewide contract with Recovery Audit Specialists (RAS), which provides services that include detection, confirmation, and collection of overpayments. RAS will report audit findings at regularly agreed-upon intervals and recommend corrective action. At the current time, the statewide contract with RAS does not address identification of underpayments; however, the state will be working to address the inclusion of activities related to underpayments in the future.
2. In Colorado, Medicaid RAC scope includes pre-payment fraud, waste, and abuse efforts not limited to credit balance audits, incorrect billing and processing errors, and lack of medical necessity. Post-payment RAC work includes data mining, medical records review, identifying overpayments. The state is not seeking any exemptions from RAC audit scope but wants RAC contractors to work with their existing MMIS vendor. The RAC contract has been awarded to CGI with HMS as a subcontractor.
3. In Delaware, RAC scope includes expanding current and ongoing Medicaid claims review and auditing processes that include high-risk areas such as dental services, hospice, pharmacy, outpatient hospital services, nursing homes, physical therapy/occupational therapy, durable medical equipment, and home health services. The state wants the look-back period to be three years from the date of the onset of the review. The RAC contract has been awarded to HMS.

CONTACT INFORMATION/LINKS:

- Medicaid RAC: medicaid-rac.com/
- Medicaid RAC activity by state: medicaid-rac.com/medicaid-rac-activity/

PERM—PAYMENT ERROR RATE MEASUREMENT

Prepared by Donna D. Wilson, RHIA, CCS, CCDS

CMS developed the Payment Error Rate Measurement (PERM) program in response to the Improper Payments Information Act of 2002 (IPIA). This act requires federal agencies to review the programs they oversee that are susceptible to significant erroneous payments and to estimate the amount of improper payments each year. The agencies are also to provide a report of these estimates and the actions being taken to reduce erroneous expenditures to Congress. The Improper Payments Elimination and Recovery Act of 2010 (IPERA) enhances IPIA and aims to further reduce improper payments. Essentially, the purpose of the PERM reviews is to measure and report a national error rate for Medicaid and the Children's Health Insurance Program on an annual basis.

SCOPE OF WORK

CMS uses national contractors to select the samples for the claims processing and medical necessity reviews, conduct the data processing and medical necessity reviews, and do the final error rate and payment calculation:

- A statistical contractor who provides statistical support by producing the samples to be reviewed and by calculating the error rate
- A documentation/database contractor who supports PERM by collecting payment related policies from states and medical records from providers
- A review contractor who examines the accuracy of the claims processing system and reviews documentation to determine the medical necessity of the service for which payment was claimed

The following issues are audited in claims processing reviews:

- Was the claim a duplicate claim?
- Was the claim paid for a non-covered service?
- Was the claim paid as a fee-for-service claim when it should have been paid as a managed care claim?
- Should the claim have been paid by a third-party liability, and if so, was third-party liability sought?
- Did the claim have a pricing error?
- Did the payment system lack system edits to correctly pay the claim (such as a gender conflict or payment for services dated after the end of eligibility/death of a recipient)?
- Did the claim have a data entry, rate cell, or managed care payment error, to name a few of the review elements?
- Was there a data entry error such as wrong dates or wrong units?

In PERM medical necessity reviews, auditors evaluate if a provider:

- Responded to the request for documentation within the required time frame
- Submitted documentation but the documentation did not support the procedure code that was reimbursed
- Submitted insufficient documentation
- Submitted a procedure code that was an error (for example, the provider performed a procedure but billed using an incorrect procedure code)
- Billed with an incorrect diagnosis

- Billed for the separate components of a procedure code when only one inclusive procedure code should have been billed
- Billed for an incorrect number of units for a particular procedure or revenue code
- Billed for a service determined to have been medically unnecessary based on the information in the medical/service record about the patient's condition
- Billed and was paid for a service that was not in agreement with a documented policy, regulation, or other requirement

RECORD REQUESTS AND LIMITS

Each state is reviewed once every three years as CMS utilizes a 17-state rotation for PERM reviews. Requested medical records must be received by the document contractor no later than the 75th day from the date on the letter. If the document contractor requests additional information, providers must submit the additional documentation within 14 days. Failure to comply with these turnaround times results in an automatic error.

The 2011 PERM error rate will have a direct impact on the number of medical record requests during the next PERM review, which is scheduled to begin in 2014.

A Sample PERM Initial Request for Records can be found in Appendix H.

CONTACT INFORMATION/LINKS

- CMS PERM: cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/index.html

MIP, MEDICAID RAC, AND PERM COMPARISON CHART:

A comparison chart between MIC/MIP, Medicaid RAC, and PERM can be found at: cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/MICRACPERM_Chart.pdf.
This chart compares the following topics for these three auditing entities:

- Authority
- Purpose
- Programs audited/measured
- Scope
- Contractors
- Audit/measurement standards
- Time frame measured/look back period
- Recoupment activities
- Appeal process
- Timeframe for response
- Documentation request
- HIPAA compliance
- Record retention requirement
- Photocopying reimbursement
- Associated CMS websites
- Technical advisory group (TAG) affiliations

OIG—HHS OFFICE OF INSPECTOR GENERAL

Update prepared by Shelley C. Safian, PhD, CCS-P; original prepared by Sharon Easterling, MHA, RHIA

Governmental audits are of great concern for providers, particularly an audit by the Office of Inspector General (OIG). Since 1993, the OIG has been performing and supervising audits and investigations of fraud and abuse to promote efficiency and effectiveness and to minimize loss of governmental programs and operations.

SCOPE OF WORK

The mission of the OIG is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. All activities performed by the OIG lie within the authority of the US Inspector General.

RECORD REQUESTS AND LIMITS

"Depending upon the nature of the alleged violations, an internal investigation will probably include interviews and a review of relevant documents. Some hospitals should consider engaging outside counsel, auditors, or healthcare experts to assist in an investigation. Records of the investigation should contain documentation of the alleged violation, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed the results of the investigation, e.g., any disciplinary action taken, and the corrective action implemented. While any action taken as the result of an investigation will necessarily vary depending upon the hospital and the situation, hospitals should strive for some consistency by utilizing sound practices and disciplinary protocols. Further, after a reasonable period, the compliance officer should review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered."[7]

Submission of Accurate Claims and Information

"Perhaps the single biggest risk area for hospitals is the preparation and submission of claims or other requests for payment from the Federal healthcare programs. It is axiomatic that all claims and requests for reimbursement from the Federal healthcare programs—and all documentation supporting such claims or requests—must be complete and accurate and must reflect reasonable and necessary services ordered by an appropriately licensed medical professional who is a participating provider in the healthcare program from which the individual or entity is seeking reimbursement. Hospitals must disclose and return any overpayments that result from mistaken or erroneous claims. Moreover, the knowing submission of a false, fraudulent, or misleading statement or claim is actionable. A hospital may be liable under the False Claims Act 9 or other statutes imposing sanctions for the submission of false claims or statements, including liability for civil money penalties (CMPs) or exclusion."[8]

The OIG has systems in place to utilize the public and private sector in assisting in eliminating fraud of HHS dollars. The whistleblower is encouraged to disclose acts of fraud and abuse to the OIG discreetly through a compliance hotline. This became a reality as a product of the False Claims Act of 1986. Compliance departments work within facilities to ensure they are aware of problems internally and can follow all internal compliance guidelines to eliminate risk and undesirable behavior. If a risk area is brought to the attention of the OIG internally or externally by an individual or through trending data, review will begin as outlined above in the supplemental guidance for hospitals.

Each year the OIG develops a work plan regarding various areas of investigation for the upcoming fiscal year. The work plan provides brief descriptions of activities that OIG plans to initiate or continue with respect to HHS programs and operations. The OIG work plan addresses a variety of provider types such as hospitals, critical access hospitals, inpatient rehabilitation facilities, long term care facilities, nursing homes, hospices, home health agencies, physicians, and other suppliers. The current year's work plan and archived work plans can be accessed at https://oig.hhs.gov/reports-and-publications/workplan/index.asp.

CONTACT INFORMATION

http://oig.hhs.gov

US Department of Justice
Office of Inspector General, Assistant Inspector General for Audit
1425 New York Ave., NW, Suite 5000, Washington, DC 20530
Voice: (202) 616-4633, Fax: (202) 616-1697

RAC—RECOVERY AUDIT CONTRACTORS

Update prepared by Linda A. Hyde, RHIA; original prepared by Pat Maccariella-Hafey, RHIA, CCS, CCS-P; Karen Cole, RHIT, CCS-P, RCC, CPC-H, CGCS

As required by Section 302 of the Tax Relief and Health Care Act of 2006, CMS has implemented Medicare recovery auditing in all states. The Recovery Audit Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that prevent future improper payments.[9]

An overview of the recovery audit program can be found at cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/RAC/01_Overview.asp.

This site provides links to the current RAC scope of work, recovery auditors' contact information, recent program updates, current programs, program provider resources, and other related information.

RAC POST-PAYMENT REVIEWS

SCOPE OF WORK

The current RAC statement of work for post-payment review can be found at cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf.

There are two major types of reviews: automated and complex. Automated reviews are done through screening of claims using various data mining techniques to identify issues without any human review of the medical record. Complex reviews are performed when there is high probability (but not certainty) that a service is not covered or where there is no Medicare policy or coding guideline available. Complex reviews require medical record review.

RECORD REQUESTS AND LIMITS

The Statement of Work outlines the time tables of request, record submission, review and appeal. CMS will set a medical record request limit that may be based on the provider type, type of claim, number of beds and/or Medicare annual payment for hospitals. The record limit will be based on location and time period. [10]

As of March 2012, the maximum number of medical records that recovery audit contractors (RACs) can request in a 45-day period from a hospital is 400. For facilities with more than $100 million in annual Medicare payments, the cap is 600 medical records.

Suppliers and physicians have their own record request limits, which may be updated by CMS from time to time. Information about current record requests limits can be found on the RAC Overview website listed above by selecting the Providers Resources link.

Per the statement of work, recovery auditors must make a determination and issue a written notice to providers within 60 days of receipt of the medical records. Failure to adhere to this notification requirement is a performance issue between CMS and the recovery auditor.

Additional information can be found in the following link to CMS Frequently Asked Questions (FAQs). Enter "recovery audit" in the search window and a list of RAC specific questions will be displayed: http://questions.cms.hhs.gov/app/answers/detail/a_id/10350.

A series of *Journal of AHIMA* articles written under the title "RAC Forensics 101," by Sharon Easterling, MHA,

RHIA, CCS, discusses the different stages of the RAC audit process. AHIMA members can access the articles using the links below:

- Part 1: Medical Record Requests and the Discussion Period
  http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_048534.hcsp?dDocName=bok1_048534
- Part 2: The Results Letter and Discussion Call
  http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_048599.hcsp?dDocName=bok1_048599
- Part 3: Denials Management
  http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_048695.hcsp?dDocName=bok1_048695

CURRENT ISSUES

The following links identify the current issues for each RAC:

- RAC A—Performant Recovery: dcsrac.com/IssuesUnderReview.aspx
- RAC B—CGI Federal, Inc.: racb.cgi.com/Issues.aspx
- RAC C—Connolly, Inc.: connolly.com/healthcare/pages/ApprovedIssues.aspx
- RAC D—Health Data Insights (HDI), Inc.: racinfo.healthdatainsights.com/Public1/NewIssues.aspx

Some examples of common focus areas include:

- Inpatient
  - MS-DRG validation and/or medical necessity reviews—Selected MS-DRGs
  - Acute inpatient hospitalization infections—Selected MS-DRGs
- Inpatient Rehabilitation Facility
  - Adherence to CMS documentation and authentication guidelines
- Inpatient Psychiatric Facility
  - Inpatient level of care criteria
  - Emergency department service charges
- Outpatient Hospital
  - Selected drug usage
  - CT scans—incorrect billing
  - Blood transfusions
  - Three-day payment window
  - Once in a lifetime procedure
- Critical Access Hospital
  - CT scans—incorrect billing
- DME
  - Duplicate billing
  - Wheelchair bundling
- Physician
  - Professional Correct Coding Initiative (CCI)
  - Bilateral indicator usage
  - Global surgery

RAC PRE-PAYMENT REVIEW

SCOPE OF WORK

In August 2012, CMS initiated a new demonstration program focusing on pre-payment review. This three-year program will evaluate whether recovery auditors can lower error rates by preventing improper payments, rather than looking for improper payments after they have occurred. Reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states.

Information about the RAC pre-payment program can be found at cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/RAC-Prepay-Review.html.

RECORD REQUESTS AND LIMITS

Currently limits on pre-payment and post-payment reviews won't typically exceed current post-payment Additional Documentation Request (ADR) limits. Claims selected for pre-payment review will be ineligible for future post-payment reviews by a CMS contractor.

CURRENT ISSUES

CMS identified claims with higher rates of improper payment based on short stay (two days or less) DRG analytics. The initial MS-DRG selected for pre-payment review is MS-DRG 312—Syncope and Collapse. Additional MS-DRGs for Transient Ischemia (MS-DRG 069), GI Hemorrhage (MS-DRGs 377-379), and Diabetes (MS-DRGs 637-639) will be phased in.

CONTACT INFORMATION/LINKS

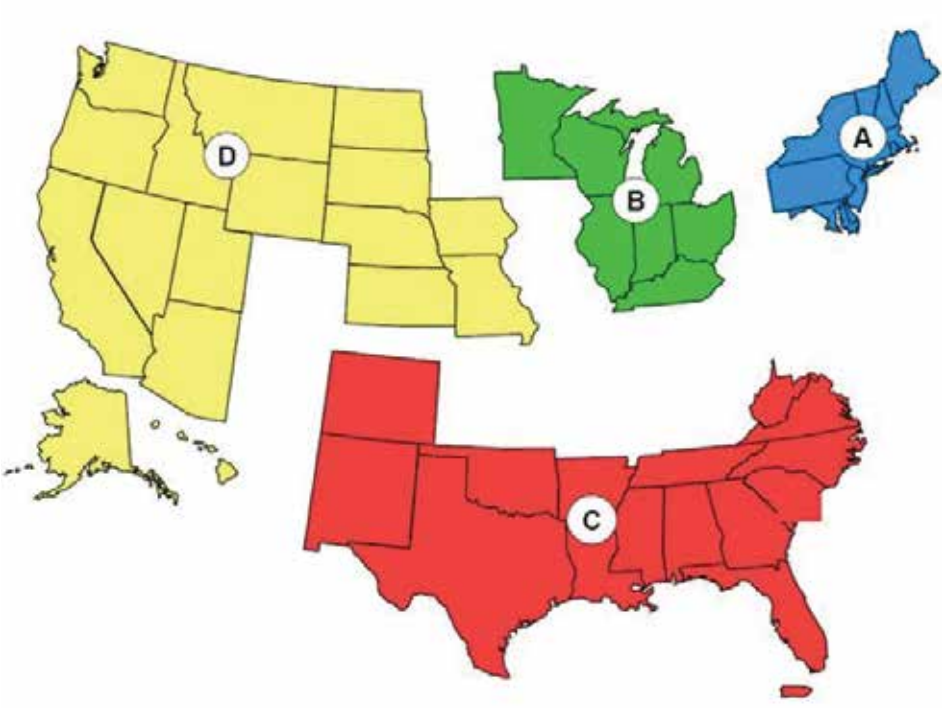
The four regional RACs include:

- RAC A—Performant Recovery— dcsrac.com/
- RAC B—CGI Federal, Inc.— http://racb.cgi.com/
- RAC C—Connolly, Inc.— connolly.com/healthcare/Pages/CMSRACProgram.aspx
- RAC D—Health Data Insights, Inc.— https://racinfo.healthdatainsights.com/home.aspx?ReturnUrl=%2f

Additional RAC resources:

- AHIMA. "Top RAC Target Areas." *Journal of AHIMA* 83, no. 7 (July 2012): 88.
- American Hospital Association. "Recovery Audit Contractor (RAC) Program." aha.org/aha/issues/RAC/index.html.
- CMS. "Recovery Audit Program." cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/index.html.
- Easterling, Sharon, and Donna D. Wilson. "Preparing for RAC Prepayment Reviews." *Journal of AHIMA* web site, August 1, 2012. http://journal.ahima.org/2012/08/01/preparing-for-rac-prepayment-reviews/
- Johnson, Kathy M., et al. "RAC Ready: How to Prepare for the Recovery Audit
- Contractor Program." *Journal of AHIMA* 80, no. 2 (Feb. 2009): 28–31.
- Medicare Learning Network. "MMA—The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative." *MLN Matters* no. SEO469. cms.hhs.gov/MLNMattersArticles/downloads/SE0469.pdf.
- Wilson, Donna D. "RAC Inpatient Coding Denials: Key Areas of Improper Payment in Permanent Program." *Journal of AHIMA* 83, no.3 (March 2012): 50-51.
- Wilson, Donna D. *Responding to a Recovery Audit Contractor (RAC) Evaluation*. Chicago, IL: AHIMA Press, 2010.

Note that the RAC jurisdictions match the durable medical equipment Medicare administrative contractor (DME MACs) jurisdictions. The following map illustrates the regions in which each RAC has jurisdiction.[11]



ZPICS: ZONE PROGRAM INTEGRITY CONTRACTORS

Update prepared by Cynthia Doyon, RHIA; original prepared by Donna Wilson, RHIA, CCS, CCDS

Effective January 26, 2009, benefit integrity work transitioned from program safeguard contractors (PSC) and the Medicare prescription drug integrity contractors (MEDIC) into zone program integrity contractors ZPICs, which are located in seven zones.

- **Zone 1**—California, Nevada, American Samoa, Guam, Hawaii, the Northern Mariana Islands, Palau, Marshall Islands, and the Federated States of Micronesia (Safe Guard Services, LLC)
- **Zone 2**—Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri (Advance Med)
- **Zone 3**—Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, and Kentucky (Cahaba)
- **Zone 4**—Colorado, New Mexico, Oklahoma, and Texas (Health Integrity LLC)
- **Zone 5**—Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia (Advance Med)
- **Zone 6**—Pennsylvania, New York, Maryland, Washington, DC, Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, and Vermont (under protest)
- **Zone 7**—Florida, Puerto Rico and Virgin Islands.(Safe Guard Services, LLC)

SCOPE OF WORK

The Scope of Work for ZPICs is very similar to the previous scope of work carried out by the PSC and MEDIC contractors. As stated within Medicare Program Integrity Transmittal 279, Change Request 6171, dated December 19, 2008: The ZPIC contracts include work for all claim types including Part A, Home Health, Hospice, Part B, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Managed Care (Part C), Part D Medicare Prescription Drug, and Medicare and Medicaid Data Matching. Part A cost report audit and reimbursement will also be added under the scope of a ZPIC contractor.

ZPICS WILL PERFORM DATA ANALYSIS TO INCLUDE THE FOLLOWING:

- Identify areas of potential errors (for example, services that may not be covered or incorrectly coded) that pose the greatest risk.
- Establish baseline data to enable the contractor to recognize unusual trends, changes in utilization over time or schemes to inappropriately maximize reimbursement.
- Identify where there is a need for a local coverage determination (LCD).
- Identify claim review strategies that efficiently prevent or address potential errors (for example, pre-payment edit specifications or parameters).
- Produce innovative views of utilization or billing patterns that illuminate potential errors.
- Identify widely over-utilized high-volume or high-cost services. This is important because these services do not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk.
- Identify and target program areas and specific providers for possible fraud investigations. This data analysis program must involve an analysis of national data furnished by CMS and review of internal billing utilization and payment data to identify potential errors.[12]

The primary goal of the ZPIC is to find cases of suspected fraud and take immediate action. All cases of potential fraud will be referred to the OIG for consideration.

RECORD REQUESTS AND LIMITS

There are no limits on the number of claims or the year of service that can be requested. ZPICs can conduct medical review of charts to decide whether the service submitted was actually provided and whether the service was medically reasonable and necessary.

CURRENT ISSUES

ZPICs can deny a claim fully or partially. Also, keep in mind that ZPICs are not required to have a physician review a claim in order to deny the claim. Nurses will probably be conducting the record reviews. Analyze all ZPIC denials and appeal inappropriately denied claims.

ZPICs vary from other CMS audits in one significant way: they may be utilized to identify Medicare fraud. With this possible implication, it is critical their targeted issues are addressed immediately. ZPICs may extrapolate overpayments using statistical sampling for their calculation methodology.

ZPIC review processes are similar to other CMS reviews. There must be evidence documented to support that the service was provided and was medically necessary and reasonable. Unacceptable documentation practices such as cut and paste, incorrect alteration methods, and potentially inappropriate late entries will be closely scrutinized.

ZPICs have more latitude when evaluating benefit integrity. They may use various approaches to tracking and trending potential patterns of fraud. If fraud is identified, the case is referred to the appropriate governmental agency. If no fraud is determined, recoupment will still be required and steps will be taken to prevent future inappropriate payments.

CONTACT INFORMATION/LINKS

- Medicare Program Integrity Manual, Chapter 4: cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
- Medicare Program Integrity Manual, Chapter 2: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c02.pdf
- Medicare Program Integrity Transmittal 446, Change Request 8079, December 28, 2012: cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R446PI.pdf
- Role of Zone Program Integrity Contractors: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1204.pdf

ZPIC MAP [13]

© Liles Parker. Used by permission.

MEDICARE ADVANTAGE RISK ADJUSTMENT VALIDATION (RADV) AUDIT

Prepared by Cynthia Doyon, RHIA

The advent of the Medicare Advantage (MA) program and Medicare Managed Care Organizations (MCOs) brought the need to evaluate the risk adjustment model being utilized. This model is based on hierarchical condition categories (HCC) coding. Rather than being paid for services rendered, physicians are reimbursed based on 70 HCC groups of ICD-9-CM diagnostic codes with similar cost-of care implications based on chronic and cumulative clinical conditions. MCOs may retrospectively audit records to ensure all appropriate and relevant codes are included on submitted claims even if they are initially unreported since they may not support the medical necessity for the service rendered.

SCOPE OF WORK

CMS will audit MA plans to ensure the data submitted is present in the documentation in the medical record. Starting in 2011 the RADV audits are used to extrapolate any error rate found to the entire contract plan.

CURRENT ISSUES

CMS strives to recover large dollar amounts from the plans going forward based on new legislation. A multiple step process is used to determine the scope of these audits.

RECORD REQUESTS AND LIMITS

The sample size is 201 enrollees. A complicated sampling methodology is utilized. The sampling methodology can be accessed on the CMS Web site, in the "Downloads" section under "Payment Validation for Part C and Part D."

CONTACT INFORMATION/LINKS

- Payment Validation for Part C and Part D: cms.gov/Medicare/Medicare-Advantage/Plan-Payment/PaymentValidation.html
- Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model: cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04summerpg119.pdf
- Medicare Advantage Risk Adjustment and Risk Adjustment Data Validation Audits: healthlawyers.org/Members/PracticeGroups/PPMC/Documents/April_12_Newsletter/crsriska.pdf

EXTERNAL (THIRD PARTY PAYER) AUDITS

With increasing regulatory scrutiny of coding, it is challenging to keep up-to-date and well versed on: AHA coding guidance, clinical interpretations, coding conventions and guidelines, and government rules.

The number of coding/MS-DRG denials from government and nongovernment payers due to lack of clinical indications to support the ICD-9-CM diagnosis code is increasing.

Areas of focus on coding-related non-governmental reviews include:

- Insufficient documentation to support the clinical significance of a diagnosis
- Cases with one CC or MCC
- Incorrect sequencing of the principal diagnosis
- Incorrect coding of procedures such as operations vs. interventional
- Incorrect application of newborn secondary diagnoses codes
- Incorrect sequencing of obstetrical records

Given these areas of focus with third-party payers, coding professionals and their managers should educate themselves on the correct coding guidelines applicable to each case. Consider implementing or working with clinical documentation improvement (CDI) to ensure secondary diagnoses are supported clinically in the medical record documentation. Share results of third-party audits with coding professionals, CDI staff, and physicians to improve your error rate.

APPEALS

There are five levels in the claims appeals process (Medicare Parts A&B), which include:

- Level 1: Request a redetermination
- Level 2: Request a reconsideration
- Level 3: Administrative law judge (ALJ) hearing
- Level 4: Appeals council review
- Level 5: Judicial review in US District Court

The procedures for appealing a determination by a government audit, for Original Medicare (Medicare Parts A&B), are explained in the CMS brochure "Medicare Appeals Process."[14] The table below summarizes the process by level of appeal.

Level of Appeal	*File Request For Review Within...*	*Claim Reviewer*	*Minimum Amount in Controversy* *	*Request Format*
Level 1 Redetermination	120 days	CMS contractor (carrier, FI or MAC)	None	Form CMS-20027 or letter**
Level 2 Reconsideration	180 days	Qualified Independent Contractor (QIC)	None	Form CMS-20033 or letter***
Level 3 Administrative Law Judge (ALJ) hearing	60 days	ALJ	$130	Form CMS-20033 or letter***
Level 4 Appeals Council Review	60 days	Appeals Council	None	As per the ALJ decision notice
Level 5 Judicial Review in US District Court	60 days	US District court judge	$1,350	As per the Appeals Council decision notice

* The amount in controversy required to request either an ALJ hearing or a judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The minimum amount in controversy threshold for 2012 is shown on the table above.

** A written request for a redetermination not made on form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested.
- Specific date(s) of service
- Name and signature of the party or the representative of the party submitting the appeal

The appellant (individual filing the appeal) should attach any supporting documentation to their redetermination request.

*** A written request for a reconsideration not made on form CMS-20033 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party submitting the appeal
- Name of the contractor that made the redetermination

The appellant (individual filing the appeal) should clearly explain the reason for disputing the reconsideration decision. A copy of the RA or MRN and any other useful documentation should be sent with the reconsideration request, along with the redetermination decision.

It is important to note that an authorized person who is familiar with the arguments contained in the letter should sign it. Such individuals include:

- Hospital CFO
- Hospital COO
- Medical director, acute rehabilitation unit
- Medical director
- HIM director for MS-DRG coding appeals
- Hospital RAC appeals coordinator
- Physician (medical necessity)
- Case management director

All governmental audit activity should be tracked in one central location that may be shared with others in the organization. Placing all correspondence into a shared database allows others to view or work on the same issue at one time.

Sample request, denial, and appeal letters can be referenced in Appendices H, I, and J. For copies of CMS Form 20027 and Form 20030, refer to Appendix L.

ICD-10-CM/PCS AND EXTERNAL AUDITING

As the healthcare industry implements ICD-10-CM/PCS, the potential for auditing will increase. Coding professionals face multiple challenges as the transition is made. These challenges include:

- Lack of familiarity with ICD-10-CM/PCS
- Limited coding advice as the American Hospital Association's *Coding Clinic* builds its library of examples and decisions
- Adequate documentation to support procedures and diagnoses
- New or revised coding guidelines

During the transition from ICD-9-CM to ICD-10-CM/PCS, the current auditing issues that involve MS-DRGs or ICD-9-CM diagnoses and procedures likely will be translated into ICD-10-CM/PCS. Some of these familiar auditing targets include MS-DRGs with one Complication/Comorbidity (CC) or one Major Complication/Comorbidity (MCC). Other challenging coding topics include sepsis and pneumonia. New auditing targets develop over time as familiarity with ICD-10-CM/PCS increases.

The following list provides potential audit areas under ICD-10-CM/PCS (note that some of these issues are present in ICD-9-CM as well):

Topic	Issue
Infectious and parasitic diseases	• Documentation of organisms • Clear documentation of symptomatic vs. non-symptomatic AIDS
Neoplasms	• Metastatic vs. primary site • Complications related to neoplasms
Blood and blood-forming organs	• Chronic vs. acute blood loss anemia • Specific types of anemia (e.g. blood loss)
Endocrine	• Documentation of diabetes type (Type I, Type II, due to drugs/chemicals, due to underlying condition, other specified • Presence of hyperglycemia • Relationship of condition to procedure (e.g., postsurgical hypothyroidism)
Mental health	• Condition related to physical condition • Differentiation between dependence, abuse, and use • Single vs. recurrent occurrences • Severity of condition (e.g., mild, moderate, severe, severe with psychotic features)
Nervous	• Dominant vs. nondominant paralysis, hemiplegia, etc. • Type of migraine • Localization or generalized epilepsy • Tractable vs. intractable epilepsy • Parkinsonism vs. secondary Parkinsonism • Early or late onset of Alzheimer's Disease
Eye/ear	• Acute vs. chronic • Glaucoma type (due to drugs, infection, trauma, or other specified type) • Intra-operative vs. post-operative hemorrhage • Laterality • Type of retinal detachment (serous, traction, w/break, etc.) • Juvenile vs. age-related cataract • Type and location of otitis
Circulatory diseases	• Rheumatic vs. non-rheumatic • Initial vs. subsequent presentation for myocardial infarction (MI) • Treatment for same MI or separate location • Specific vessel involved with MI • Native vs. bypass grafts vs. transplanted heart • Autologous vs. non-autologous grafts • Angina type (stable, unstable, spasm) • Congestive heart failure type (systolic, diastolic, combination) • Intra-operative vs. post-operative hemorrhages • Specific residuals from stroke • Type of stroke (embolic, thrombotic, hemorrhagic, traumatic, non-traumatic) • Acute or chronic embolism or thrombosis

Respiratory diseases	• Severity of asthma (mild, moderate, severe, intermittent, persistent, exacerbation, with status asthmaticus, combination) • Tobacco status • Organisms associated with pneumonia • Intra-operative or post-operative complications • Iatrogenic pneumothorax
Digestive diseases	• Relationship with alcohol use, abuse, and dependence or drug use, abuse and dependence • Acute vs. chronic • Intestinal hemorrhage or abscess with other conditions • Hernia—recurrent or non-recurrent and with or without gangrene • Ulcers with or without hemorrhage, perforation or both • Intra-operative or post-operative complications
Skin and subcutaneous tissue diseases	• Site and stage of pressure ulcer • Site and extent of non-pressure ulcers
Musculoskeletal diseases	• Type of healing (routine, delayed healing, nonunion, malunion) • Type of arthropathy (infectious w/organism, direct infection, post-immunization, reactive, etc.) • Complications of rheumatoid arthritis (lung involvement, vasculitis, heart disease, myopathy, polyneuropathy, rheumatoid factor, bursitis, nodule, juvenile) • Gout types (idiopathic, lead-induced, drug-induced, secondary) • Acquired vs. congenital deformities • Intra-operative vs. post-operative complications
Genitourinary diseases	• Acute vs. chronic • Mild vs. diffuse • Stage of chronic kidney disease • Failure vs. insufficiency • Ureter vs. urethra • Intra-operative vs. post-operative complications
Pregnancy	• Complete vs. incomplete abortion • Pre-existing conditions (before pregnancy) • Excessive vs. low weight gain in pregnancy • Conditions applying to fetus 1 through fetus 5 • Obstetric laceration specificity • Pregnancy trimester • Pregnancy completed weeks

Perinatal	• Suspected conditions associated with symptoms • Birth weight • Gestational age • Drugs associated with reactions in baby
Congenital malformations or chromosomal abnormalities	• Congenital vs. acquired, specify the congenital abnormality
Symptoms	• Organ dysfunction related to sepsis • Presence of SIRS • Significant abnormal test results
Injuries and poisonings	• Type of fracture (Type I, II, III, open, closed, LeFort, dens, burst, wedge compression, Zone I, displaced, Salter-Harris Type I, Colles, etc.) • Site of fracture, laterality • Traumatic vs. nontraumatic fractures • Stage of healing (routine, delayed healing, nonunion, malunion) • Unconsciousness duration, if present • Complete vs. incomplete spinal cord lesion • Complete vs. partial amputation • Specific muscle or blood vessel injuries • Burn degree and BSA/TSA % involved • Active treatment vs. follow-up care vs. sequela
External causes of morbidity	• Type of vehicle (motor, non-motor, pedestrian conveyance) • Role of injured person (driver, pedestrian, etc.) • Place of occurrence • Classification of poisoning (accidental, intentional, therapeutic, assault, undetermined) • Active treatment vs. follow-up care vs. sequela • Patient activity at the time of injury/condition • Nosocomial or community acquired
Procedures	• Using the root operation correctly—there will be some pairs that will be under specific review—Alteration vs. Repair; Occlusion vs. Restriction; Excision vs. Resection

It is also necessary to keep in mind that even with the implementation of ICD-10-CM/PCS, ICD-9-CM will still be under review for several years as governmental and external auditors continue to work through claims prior to October 1, 2014. Please note that CPT/HCPCS issues will remain the same, as CPT/HCPCS is not affected by the advent of ICD-10-CM/PCS.

Notes

1. US Department of Health and Human Services. "HEAT Task Force." stopmedicarefraud.gov/aboutfraud/heattaskforce/index.html
2. Ibid.
3. Centers for Medicare and Medicaid Services. "Medicare Administrative Contractor (MAC) Jurisdiction Fact Sheet." July 2010. cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/downloads/MAC-JurisdictionFactSheet.pdf
4. Ibid.
5. CMS. "Consolidated A/B/ MAC Jurisdiction Map." cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/Jurisdiction-Maps/ConsolidatedABMACMap.pdf
6. CMS. "Program Integrity." medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Program-Integrity/Program-Integrity.html
7. *Federal Register* vol. 63, no. 35, February 23, 1998, p. 8797. oig.hhs.gov/authorities/docs/cpghosp.pdf
8. *Federal Register* vol. 70, no. 19, January 31, 2005, p. 4858. oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf
9. CMS. "Statement of Work for the Recovery Audit Program." September 1, 2011. cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf
10. Ibid.
11. American Hospital Association. "RAC National Program and Contractor Information." aha.org/aha/issues/RAC/contractors.html
12. CMS. "Zone Program Integrity Contractor (ZPIC) Updates." CMS Manual System, Pub 100-08 Medicare Program Integrity, Transmittal 279, December 19, 2008. cms.gov/transmittals/downloads/R279PI.pdf
13. Liles Parker (law firm). zpicaudit.com/wp-content/uploads/2011/01/Zpic-Map-big.jpg
14. CMS. "The Medicare Appeals Process." June 2012. cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf

APPENDIX A

PREPARATION CHECKLIST FOR GOVERNMENTAL AND EXTERNAL AUDITS

A. Choose audit team from key departments involved (Appendix B)

- Administration
- Audit coordinator
- Utilization/case management/care coordination
- Health information (HIM)
- Health information (coding)
- Medical staff
- Clinical documentation improvement management
- Patient financial services/revenue cycle/revenue integrity
- Information services (IT)
- Clinical department managers (as needed)
- Quality management/performance improvement
- Research
- Corporate compliance
- Internal audit
- Finance/reimbursement
- Contract management
- Office of general counsel/internal and external
- Patient access/scheduling/registration
- External consultants (as needed)

B. Contact person/persons for all audit communication incoming and outgoing (Appendix C)

- Primary POC (point of contact) and back-up
  - Tracking system/chart requests all tracking should be in one location
- Database or file
- Contact numbers for each governmental auditor
- Contact numbers in-house applicable staff

C. Education for key players (Appendix E–F)

- Know the scope of work for each audit
- Develop proactive approach for education
- Education for audit team
- Education other personnel

D. Know the importance of release of information (ROI) role (Appendix D–E)

- What to copy from chart
- Numbering of chart pages
- How many copies and who they should be sent to in-house and RAC personnel
- How to send/ship/submit electronically for signature of receipt from reviewing agency (date and time)
- Determine if online access capabilities exist
- Correct name and address of contractor
- Response time limits
- Follow-up with auditor to ensure payment, if applicable

E. Town hall meeting—provider outreach sessions

- All RAC contractors are required to hold in each state prior to entering state
- Times and dates (cms.gov) or contractor's website (they should notify you)

F. Automated review vs. complex review

- Automated review occurs when a RAC makes a claim Determination at the system level without a human review of the medical record—data mining
- Complex review occurs when a RAC makes a claim determination utilizing human review of the medical record

G. Appeals process. . .Who should submit

- The appeal letter should be signed by an authorized person who is familiar with the arguments contained in the letter, such as:
  - Hospital CFO
  - Hospital COO
  - Medical director, acute rehabilitation unit
  - Medical director
  - HIM director for DRG coding appeals
  - Hospital RAC appeals coordinator
  - Physician (medical necessity)
  - Case management director

H. Time frames

- Be aware of time frames for each audit (can vary)

I. Identify targets

- Inpatient
- Outpatient
- Therapies
- Surgical procedures
- Incomplete documentation and /or interpretation
- E/M levels
- Units of service
- DRG
- Coding errors
- Medical necessity
- Lab, radiology
- Infusion and transfusion
- Social worker services in facilities
- Place of service errors
- Incident-to error
- Stark violations
- Duplicate billing
- Debridement coding
- Lysis of adhesions
- Coagulopathy
- Cases with only one CC or MCC
- Pharmaceutical coding

J. Understand the hierarchy of reporting

- Potential fraud to CMS
- Potential quality issues to QIO

APPENDIX B

HIERARCHY OF AUTHORITY

Governmental and External Audit Contact Personnel

This document may be tailored to your organization.

Department/Position	Role	Contact Name	Position	Contact Number	E-mail Address	Interview Date/Time
Administration	Executive champion					
Audit Coordinator	Focal point of all RAC activity					
Utilization Management/ Case Management	Identify medical necessity or wrong setting issues; work with medical staff					
Health Information Management (HIM)	Provide medical documentation and assist with data mining					
Health Information Management (Coding)	Assist in data mining, identification of difficult to code areas, be part of the solution					
Medical Staff/CDI	Improve documentation					
Patient Financial Services/ Revenue cycle/Revenue Integrity	Identify charging/ billing issues; assist in data mining					
Information Systems (IS)	Provide IT support to data mining; software installation; provision of electronic records					
Clinical Department Managers (as needed)	Provide assistance on ad hoc basis; identify difficult to charge scenarios; ad hoc member; be part of the solution					
Quality Management/ Performance Improvement	Track/trend improvements; create solutions					
Research	Provide information regarding clinical trials and any charging/coding difficulties					

Internal Audit	Perform special audits in areas of focus					
Corporate Compliance	Develop compliance action plan on identified issues; assist with self- reporting/ disclosure; assist in problem solving; liaison with legal contact					
Finance/ Reimbursement	Track financial exposure					
Contract Management	Identify other payers with follow up audits; assist in identifying difficult to code/charge/bill areas					
Office of General Counsel—Internal/External	Provide support to any litigation or identified legal issue					
Patient Access/ Scheduling/ Registration	Assist with medical necessity, patient type issues; be part of the solution					
External Consultants (as needed)	Assist in the appeal and audit process. provide education					

APPENDIX C

AUDIT COORDINATOR JOB SKILL SET SAMPLE

The attributes of the audit coordinator are:

- Management skills including managing hospital coding/billing audits to ensure proper documentation, reimbursement, and billing for all chargeable services
- Ability to educate physicians, CDI, and coding professionals on coding and/or documentation guidelines
- Knowledge of healthcare compliance as well as legal and governmental rules and regulations
- Knowledge of current trends and developments in coding and/or documentation
- Current clinical knowledge through reading, attending seminars, or informal sessions with other departments and physicians
- Must report to all levels of the organization, including administration
- Organized with strong project management skills and effective in influencing others without having direct lines of authority
- Ability to work at a detail level while also seeing the big picture.
- Excellent time management skills with the ability to organize, prioritize, and complete workload within deadlines; identify obstacles and problem solve while working independently
- Must have knowledge of CCI edits, LMRPs, LCDs, and NCDs, as well as other federal and private payer billing requirements
- Effective negotiating skills, which include the ability to resolve difficult claim issues, apply clinical assessment skills to the medical record, and extract supportive documentation for audit purposes is required
- Ability to understand and apply patient care protocols (standards of regulatory and accrediting) to interpret care rendered with regard to billing practices
- Ability to operate general office equipment
- Highly effective oral and written communication skills to convey information successfully and to document accurately and completely
- Ability to maintain the confidentiality of sensitive information
- Demonstrated knowledge of computer technology and automated systems for health information management, case management, etc. Knowledge of MS Office including Word, Excel, and Power Point

Duties/roles and responsibilities of the audit coordinator:

- Ownership of all audit activity in the tracking mechanism
  - Trending data related to denials, appeals, etc.
- Evaluate and make recommendations regarding tracking tool utilized
- Open communication
  - Between audit coordinator and administration
  - Between audit coordinator and patient financial services
  - Between audit coordinator between UR/case management/physician advisor/CID/clinical managers for clinical review
  - Between audit coordinator and governmental and external audit contractors

- Coordination of all activities associated with audit requests, appeals, etc.
- Tracking handoffs between departments
- Invoicing of submitted records requests, if applicable
- Tracking of audit timelines for requests and audit responses
- Oversight of all audit activity
- Communication with all affective external entities involved in the audit process
- Participation on all assigned committees deemed appropriate by the organization
- Evaluate and make recommendations regarding tracking tool utilized
- Develop strategic and tactical plans for all audit activities

Education, Training, and Experience:

- HIM credential required (RHIA or RHIT; CCS preferred)
- Bachelor degree level
- Coding knowledge
- Minimum five years experience in HIM management; case management or utilization review or clinical documentation improvement
- Experience with claim denials, audit management, and appeal processing. Prefer knowledge related to the federal appeal process up to and including administrative law judge reviews

Other functions required (outside of audit coordinator)

- Clinical review
- Clerical/administrative support for audit tracking mechanism data entry
- Release of information process/functions

APPENDIX D

Policy and Procedure Samples

MEDICAL RECORD QUALITY ASSURANCE/EXTERNAL REVIEW AGENCY POLICY AND PROCEDURE

Created:

Last Revised:

Reviewed:

SUMMARY STATEMENT

Upon receipt of a medical record request from enter auditing body, all requested documents and/or a complete medical record for the date of service requested must be submitted to enter auditing body within _____ days of the request. It is necessary to provide a consistent and accurate process to ensure the medical record represents the patient encounter as billed and includes a complete copy of all documents for the date of service requested prior to mailing. It is also necessary to ensure the record is mailed in a timely manner.

Applicability

This policy applies to enter all responsible parties (i.e., medical records, correspondence, internal audit department, etc.)

Policy

To process request, monitor status of requests and update the _____ tracking tool in response to enter auditing body's medical record requests.

Procedure

1. The quality analyst shall receive documentation obtained from medical records prior to mailing.
2. The quality analyst should be knowledgeable of submission requirements outlined by the payer.
    a. Sources of requirements
        i. Request letter
        ii. Payer websites
        iii. NCDs/LCDs
        iv. Other communication
3. The medical record quality analysis sheet (Attachment 1) will be used to validate the content of the record that has been received. The completed quality analysis sheet is to be maintained on file until submission is complete and all appeals have been exhausted (if applicable).
    a. If all the contents of the medical record are present per the request.
    b. If the medical record is found to be incomplete or contain duplicate of non-applicable information.
        i. . The Quality Analyst will notify the health information management (HIM) department of the finding and invalidate the quality analysis sheet.
        ii. The HIM department will re-submit the record.
        iii. The quality analyst will again verify the record is complete per the quality analysis guidelines.
4. The quality analyst will submit the record for mailing.
5. All records will be tracked for delivery and receipt with follow-up as appropriate.

MEDICAL RECORD QA SHEET						
Name:	Date of Request:					
Medical Record #:	Account #:					
Date(s) of Service:	Enter Auditing Body Request DUE DATE:					
VERIFY PATIENT IDENTIFIERS PER RAC REQUEST:	✓(verified)		Initials			
• HIC/MEDICARE NUMBER						
• DATE OF BIRTH						
• DATE OF ADMISSION						
• DATE OF DISCHARGE						
• Valid Approved RAC Issue (if applicable)						
• Combined Account -Other Date of Service to be included:						
	✓ present	Not on Chart	**Requested Date**	Record .	N/A	Initials
Face Sheet						
ED Notes						
H & P						
Consults						
Discharge Summary						
MD Orders (signed and dated)						
Level of Care Orders						
Progress Notes						

	✓present	Not on Chart	Requested Date	Record Rcvd.	N/A	Initials
Labs						
Radiology Reports						
Nursing Notes						
Interdisciplinary Notes						
Medication Sheets						
Surgery/Procedure Notes						
Cath. Lab Report						
Case Management						
UB 04 (if requested)						
Additional Records Needed:						
PT/OT/ST						
Other areas records are maintained						
Paper Record						
Electronic Health Record Information						
MD Office Records and Orders						

<table>
<tr><td colspan="4">Missing Records: (document missing records—for example op report, progress notes, etc.)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Why is record missing?</td></tr>
<tr><td colspan="4">Record Located? (y/n) If no, explain.
If no, explain</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Initials:</td></tr>
<tr><td>Mailing Prep:</td><td>✓</td><td>Initials :</td><td>Final Verification by:</td></tr>
<tr><td>• All copies legible</td><td></td><td></td><td></td></tr>
<tr><td>• TOTAL pages copied back and front (total number of pages)
Pages</td><td></td><td></td><td></td></tr>
<tr><td>• Records in chronological/date order</td><td></td><td></td><td rowspan="2">Date Mailed:</td></tr>
<tr><td>• Tabs Included in copies</td><td></td><td></td></tr>
<tr><td>• Check loose materials</td><td></td><td></td><td></td></tr>
<tr><td>Signature:</td><td colspan="2">Date:</td><td rowspan="2">Return to HIM director or designee</td></tr>
<tr><td>Signature:</td><td colspan="2">Date:</td></tr>
</table>

COMPLEX MS-DRG VALIDATION/CODING APPEAL PROCESS

Created:

Last Revised:

Reviewed:

SUMMARY STATEMENT

Upon receipt of the complex MS-DRG validation/coding review determination by the enter auditing body, providers have the right to appeal. The appeals process may vary by payer. The Medicare Appeals Process for the Recovery Audit Contractor program (RAC) consists of a period of discussion and five appeal levels. It is necessary to provide a consistent and accurate process for timely submission and monitoring of the status and level of appeal. This requires a uniform procedure for review of and response to denial determinations.

Applicability

This policy applies to the audit coordinator, coding department, and other applicable ancillary departments.

Policy

To process and monitor denial determinations and the appeals process in reference to the Medicare RAC program.

Procedure

1. Upon receipt of the review results letter from the RAC Contractor, the letter will be scanned into the tracking system or routed appropriately. The timer will start based on the date of the letter (a period of 15 days to file for discussion until demand letter, 30 days for notification of appeal intent to Medicare Administrative Contractor (MAC) previously known as Fiscal Intermediary (FI) to stop recoupment and/or 120 days maximum to appeal to the FI Level 1).
2. The assigned coder will review the RAC review results letter for denial reason and make a decision to appeal within three business days of receipt.
3. The coder (who may collaborate with documentation specialist or physician advisor as needed) will review the medical record to assist with clinical guidance and determination of agreement or disagreement with the RAC determination.
    a. If the review findings are in agreement with the RAC determination:
        i. Record will be reviewed by a second coder for agreement as needed.
        ii. If a second coder review is in agreement with RAC determination, payment will be made upon receipt of the demand letter and cased closed.
        iii. Detailed notes will be maintained in the tracking system.
    b. If the review findings are not in agreement with RAC determination:
        i. Record will be reviewed by a second coder as needed.
            1. If second review results in disagreement with RAC determination: Findings will be discussed with audit coordinator/interdisciplinary team as warranted regarding decision to appeal findings.

4. If decision to appeal is made to discuss case, the coding manager will prepare outline of supporting appeal information in preparation for discussion call with RAC before day 15. Interdisciplinary team member(s), attending physician and physician advisor may be contacted for appeal direction.
    a. A discussion form will be submitted to discuss the case via fax and/or supporting information at least 24 hours before the call.
    b. The coding manager will discuss the case with the RAC reviewer at scheduled time or physician to physician discussion may be scheduled with RAC medical director.
5. Based on the discussion, a decision will be made regarding overturn of the denial or the denial being upheld by the RAC.
    a. If the review findings are overturned by the RAC:
        i. Details will be documented in tracking system.
        ii. Case will be completed and closed.
    b. If the RAC review findings are upheld after the discussion:
        i. The coding manager will document details of the discussion in the tracking tool notes.
        ii. The audit coordinator, interdisciplinary team, and/or other appropriate team members will meet to discuss the final RAC determination and decide on further appeal.
6. If the decision is made to appeal to Level 1 (Redetermination)
    a. The coding manager will draft the appeal letter and attach any supporting documentation.
    b. The letter will be reviewed by a second representative as needed,
    c. Upon final approval of the appeal letter, the appropriate forms for Level 1 will be completed and attached with appeal letter, documentation and a copy of the entire medical record.
    d. The appeal documentation will be mailed within 30 days of the date of the demand letter.
        i. Mailing information should be documented for tracking purposes (mailing date, mail service used, tracking number) by responsible party.
        ii. Upon confirmation of receipt, tracking system will be updated with the date of receipt and name of signer by responsible party.
7. Audit coordinator will monitor for appeal decision within the designated response time period (for example 60 days for Level 1).
    a. If RAC decision is overturned, proceed to step 1.
    b. If RAC decision is upheld at Level 1, repeat steps 1–8.
8. Monthly denial management meetings will be held with the interdisciplinary team.

APPENDIX E

DEVELOPING AN EDUCATION PROGRAM

Purpose: Identify the educational needs for healthcare providers when implementing their internal processes and procedures for governmental and external audits.

A. Preparing for education

1. Identify who needs to be educated.

- Use the multidisciplinary audit contacts worksheet to identify the key roles and departments having some level of responsibility for the audit programs.
- This list can serve as your audience for education and from this you can identify the level of information each group will need and how to provide it.

2. Identify level of education needed

- Administration/stakeholders: This group will need to understand the high-level program requirements and the level of internal resources required to manage the program. Department heads must understand their level of involvement in the program and how it will relate to other departments.
- Medical staff/CDI/coding professionals: The medical staff /CDI/coding professionals' education should include the overview of the audit programs, how they affect the facility, and where they are affected in terms of documentation practices. In addition, since individual providers are subject to governmental and external audit requests, your education can help them understand how their own office staff is affected and what they will need to do in preparation.
- Day-to-day staff: These staff require the most detailed education in understanding the processes and procedures to follow to fulfill governmental and external audit requests and manage requests and the appeals process.

3. Create an educational schedule and determine method(s) of education.

- Can you use existing meetings (medical staff, administration) to provide initial high-level education?
- Education schedule should be developed according to timelines that coordinate with implementation of the program and when you must start preparing. Administration may need earlier education to understand the resource requirements and to approve the selection of the key contacts and department roles.
    - Create multiple methods of education including face-to-face presentations, newsletters, fact sheets to tailor information needs to the audience, and to reinforce important information over time. Short focused presentations followed by fact sheets or FAQs may be appropriate to certain types of audiences.

4. Identify individuals responsible for planning and providing education.

    - Does your facility have an internal training staff that can help in the development of materials and coordinate the training program, or do you need to identify a resource to serve in this capacity?
    - Provide trainer(s) with the necessary education, support materials and external resources to learn about governmental and external audits.
    - Provide any external background material and sample educational material to use to develop/tailor presentations to your facility.
    - Use examples of educational programs from other facilities, CMS, OIG, or sample templates to help develop your materials.

B. Key concepts and resources needed to support governmental and external audit education:

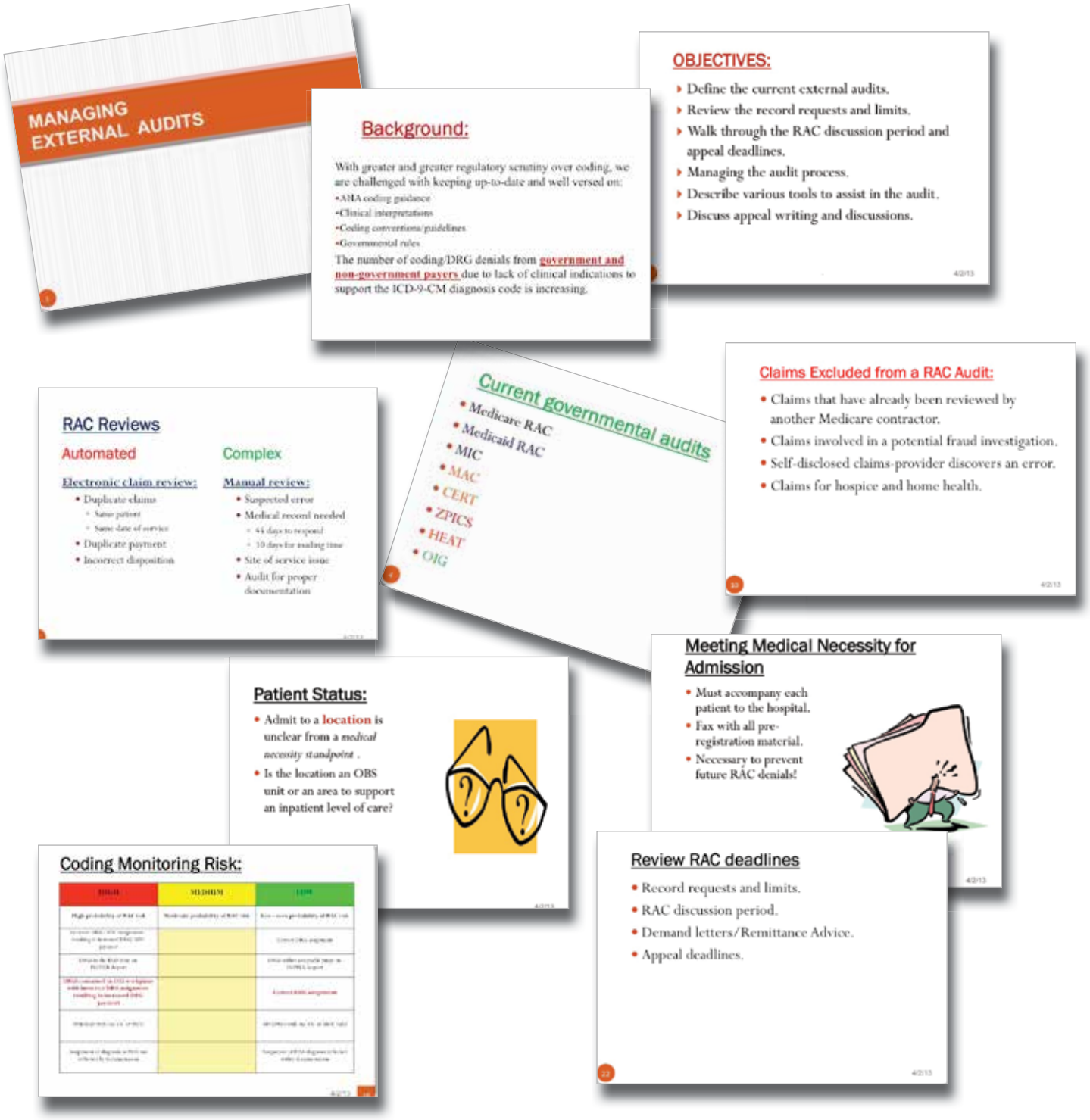
1. What are the current governmental and external audits and where did they come from?
2. How do the governmental and external audits work?
3. Types of providers included in the current governmental and external audits?
4. Describe the general governmental and external audit processes (request for records, submission, tracking, appeals, etc.).
5. Describe how governmental and external audit processes will be managed in your facility, including key staff, process flow, overall management responsibility.
6. Understand acronyms (Appendix K).
7. Discussion of governmental and external audit findings.

APPENDIX F

PRESENTATION SAMPLE

Presentation Title: Managing External Audits

Download the full presentation at: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050183.pptx



APPENDIX G

CURRENT MEDICARE ADMINISTRATIVE CONTRACTORS (MACS)

STATE	MAC PART A	MAC PART B	LINK
Alabama			
	Cahaba Government Benefit Administrators®, LLC	Cahaba Government Benefit Administrators®, LLC	cahabagba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Alaska			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
American Samoa			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
Arizona			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Arkansas			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
California			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
Colorado			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Connecticut			
	National Government Services, Inc.	National Government Services, Inc.	ngsmedicare.com

	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Delaware			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
District of Columbia			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Florida			
	First Coast Service Options, Inc.	First Coast Service Options, Inc.	http://medicare.fcso.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Georgia			
	Cahaba Government Benefit Administrators®, LLC	Cahaba Government Benefit Administrators®, LLC	cahabagba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Guam			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
Hawaii			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
Idaho			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com/
Illinois			
	Wisconsin Physicians Service Insurance Corporation	N/A	wpsmedicare.com
Indiana			
	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Iowa			

	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Kansas			
	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Kentucky			
	CGS Administrators, LLC	CGS Administrators, LLC	cgsmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Louisiana			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Maine			
	NHIC Corp.	NHIC Corp.	medicarenhic.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Maryland			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Massachu-setts			
	NHIC Corp.	NHIC Corp.	medicarenhic.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Michigan			
	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Minnesota			
	Wisconsin Physicians Service Insurance Corporation	N/A	wpsmedicare.com
Mississippi			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com

	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Missouri			
	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Montana			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Nebraska			
	Wisconsin Physicians Service Insurance Corporation	Wisconsin Physicians Service Insurance Corporation	wpsmedicare.com
Nevada			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
New Hampshire			
	NHIC Corp.	NHIC Corp.	medicarenhic.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
New Jersey			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
New Mexico			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
New York			
	National Government Services, Inc.	National Government Services, Inc.	ngsmedicare.com
North Carolina			
	Palmetto GBA	Palmetto GBA	palmettogba.com

	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
North Dakota			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Northern Mariana Islands			
	Palmetto GBA	Palmetto GBA	palmettogba.com/j1
Ohio			
	CGS Administrators, LLC	CGS Administrators, LLC	cgsmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Oklahoma			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Oregon			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Pennsylvania			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Puerto Rico			
	First Coast Service Options, Inc.	First Coast Service Options, Inc.	http://medicare.fcso.com
Rhode Island			
	NHIC Corp.	NHIC Corp.	medicarenhic.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
South Carolina			

	Palmetto GBA	Palmetto GBA	palmettogba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
South Dakota			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Tennessee			
	Cahaba Government Benefit Administrators®, LLC	Cahaba Government Benefit Administrators®, LLC	cahabagba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Texas			
	Novitas Solutions, Inc.	Novitas Solutions, Inc.	novitas-solutions.com
Utah			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Vermont			
	NHIC Corp.	NHIC Corp.	medicarenhic.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Virgin Islands			
	First Coast Service Options, Inc.	First Coast Service Options, Inc.	http://medicare.fcso.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Virginia			
	Palmetto GBA	Palmetto GBA	palmettogba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com

Washington			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
West Virginia			
	Palmetto GBA	Palmetto GBA	palmettogba.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com
Wisconsin			
	Wisconsin Physicians Service Insurance Corporation	N/A	wpsmedicare.com
Wyoming			
	Noridian Administrative Services, LLC	Noridian Administrative Services, LLC	noridianmedicare.com
	Wisconsin Physicians Service Insurance Corporation		wpsmedicare.com

References:

CMS. "Contacts For Part A—Medicare Administrative Contractor (MAC—Part A) Alphabetical Index." cms.gov/medicare-coverage-database/indexes/contacts-part-a-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&

CMS. "Contacts For Part B—Medicare Administrative Contractor (MAC—Part B) Alphabetical Index." cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&

CMS. "Contacts List of Contractor Websites." cms.gov/medicare-coverage-database/indexes/contacts-contractor-websites-index.aspx?bc=AgAAAAAAAAAA&

APPENDIX H

SAMPLE REQUEST LETTERS

SAMPLE: OIG Letter from Department of Health and Human Services, Office of Inspector General, Office of Audit Services, (appropriate region)

The Office of Inspector General is presently conducting a review of aberrant Medicare payments for inpatient and outpatient services. The objective of this review is to evaluate controls used to adjudicate potentially excessive Medicare payments submitted by institutional providers for inpatient and outpatient services.

To accomplish our objective, we utilized the Center for Medicare and Medicaid Services' National Claims History file for calendar years 2004–2005 and extracted all claims with a paid amount in excess of $200,000 for inpatient services and $50,000 for outpatient services. Enclosed is a detailed list of claims with paid amounts greater than the stated thresholds. Furthermore, according to the Common Working File, the claims have not been cancelled or amended. We request that you research and report on the following:

1. Is the information on this claim correct—specifically, is the number of units rendered correct?
2. If the service(s) were billed in error, what should the correct number of units rendered be?
3. What controls do you have in place to ensure overpayments resulting from erroneous units or charges are identified and refunded to the Medicare program and beneficiary?
4. If controls are in place, what is the reason this overpayment was not identified and refunded?
5. If controls are not in place, what is your corrective action plan to prevent erroneous billings and to identify erroneous payments?

The requested information should be returned no later than 30 days from the date of this letter to:

(Name)

(Local OIG address)

This information will be provided to (local agency).

The information is sought by the Office of Inspector General in its capacity as a health oversight agency, and this information is necessary to further health oversight activities. Disclosure is therefore, permitted under the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy and Individually Identifiable Health Information 45 C.F.R. 164.501; 164.512(a); and 164.512(d). Furthermore, Section 6 of the Inspector General Act of 1978, as amended, authorizes all access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the applicable establishment which relates to programs and operations with respect to which that Inspector General has responsibilities under this Act.

If you have any question, please call me at (___)___-_____ Please refer to report numbers (located at top of correspondence) in all correspondence.

Sincerely,

(Name)

Audit Manager

SAMPLE PERM RECORD REQUEST

PERM— INITIAL REQUEST FOR RECORDS DATE:

PERM ID:
Please send ASAP but no later than the due date

Provider Name: **Due Date:**

Provider #:

Provider Address:

Provider Address Line 2:

City, State Zip Code:

Dear Medicaid Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in the Medicaid program under the Payment Error Rate Measurement (PERM) program. You are receiving this letter today because a claim for a service you rendered has been randomly selected for review under this program. We are requesting a complete copy of the medical/supporting record pertaining to this specific claim to provide documentation that the service was medically necessary and/or paid in compliance with state policy.

Your cooperation in submitting the requested documentation to us as soon as possible, but no later than the due date noted above is essential to ensure the claim is accurately reviewed to determine proper payment. If you do not provide the record, the claim will be cited as an erroneous payment and your State Medicaid agency may pursue recovery of payment for this claim.

We request the medical record or other supporting documentation regarding the claim identified on the following enclosures:

- Claim Summary Sheet—Includes details regarding patient name, recipient ID, date of birth, and dates of service for the claim selected.
- A bar-coded PERM cover sheet—Please submit all relevant documents listed on the bar-coded PERM cover sheet for the identified claim's dates of service only. Instructions for submitting requested record/documentation are also included.

The CMS has the authority to collect this information under section 1902(a)(27) of the Social Security Act, which requires providers to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for furnishing services. The collection and review of protected health information contained in individual-level medical records for payment review purposes, as required under this effort, complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Privacy Rule regulations at 45 CFR Parts 160 and 164. Additional information regarding this request as well as PERM FAQs is addressed on the CMS PERM provider website (cms.hhs.gov/PERM/06_Providers.asp#TopOfPage).

In order to expedite the processing of your submitted documentation, please make sure the record is received in our office, along with the bar-coded cover sheet, no later than the due date printed at the top of this letter. Should you require additional information or have questions, please call our customer service representatives at (__)___-_____ or your State Medicaid representative, _____ at _____ .

Thank you for your cooperation and assistance in our efforts to ensure the integrity of the Medicaid program.

Sincerely yours,

Medical Record Manager
PERM Review Contractor
Enclosures

APPENDIX I

SAMPLE DENIAL LETTERS

THIS IS A SAMPLE COPY OF INPATIENT RAC DENIAL LETTER.

Your RAC region letter may be slightly different.

Provider Name: XYZ Hospital
Request #: 201xxxxxxxxxx7-4xxxx99
Request Date: 7/30/2012
ADR Letter Date: 6/15/2012

Claim/ Ref #	Med Rec #	Begin DOS	End DOS	Mem DOB	Member	Patient Ctrl #
Mem Last Name						
2xxxxxxxxx2 03	123456	2/20/09	2/22/09	01/28/ 1923	XXXXXXXXD	2xxxx4
Name Here						

Hospital Diag Code	Revised Diag Code	Hospital Proc Code	Revised Proc Code
276.51	276.51	86.22	86.28
584.9	584.9		
707.23	707.23		
682.7	682.7		
707.07	707.07		
707.03	707.03		
401.9	401.9		

DRG:	620
Revised DRG	**640**
Claim total Charges	$26,609.23
Reimbursement Amount:	$14,839.01
Projected Recovery Amount:	**$8,576.35**

Auditor: [Name of auditor here with credentials]
[Phone number of auditor here]

Reviewer Rationale:
The patient is a 70-year-old male who presented with a right heel ulcer. Per review of the operation notes it does not appear that an excisional debridement (86.22) was performed, so therefore, 86.28 (nonexcisional debridement) should have been assigned. Please review *Coding Clinic* 2008 First quarter indicating the use of a sharp instrument does not always indicate that an excisional debridement was performed.

[The RAC Contractor Logo and RAC contact information appears here at the bottom of the denial letter]

APPENDIX J

SAMPLE APPEAL LETTERS

This is a sample copy of inpatient RAC appeal letter

June 17, 2012
Via [Mode of Delivery: Certified Mail/Federal Express/etc.]
[RAC Contractor Name Here]
Attn: [Name of Auditor here with credentials]
[RAC Contractor Address Here]

Subject:	Request for Reconsideration/Redetermination
Facility Name:	XYZ Hospital
Provider ID:	[National Provider Identifier (NPI)]
Patient Name:	[Patient Name here]
Request #:	201xxxxxxxxxx7-4xxxx99
Claim /Ref#	2xxxxxxxx2 03
Account #:	2xxxx4
Medical Record #:	123456
HIC #:	XXXXXXXXD
Date of Service:	02/20/09 – 02/22/09

By way of this letter, we dispute the denial of payment for this claim and request a reconsideration of this decision. The initial payment determination on this claim was made in September 2009. [Insert RAC Contractor name here] reopened the claim and denied it on April 16, 2010, changing the DRG from DRG 622, Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC (RW 3.1728) to DRG 640, Skin Nutritional & misc metabolic disorders w MCC (RW 1.1138). A copy of the original denial letter is attached. [Insert RAC Contractor name here] provided the following explanation for the denial:

Patient is a 70-year-old male who presented with a right heel ulcer. Per review of the operation notes it does not appear an excisional debridement (86.22) was performed, so therefore, 86.28 (non excisional debridement) should have been assigned. Please review *Coding Clinic* 2008 First quarter indicating the use of a sharp instrument does not always indicate an excisional debridement was performed. We are appealing this denial and provide the following justification for its reversal and reconsideration of a DRG 622, Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC (RW 3.1728) based on operative report documentation by the surgeon and in the progress notes, and AHA *Coding Clinic* guidance.

The 2/20 note states "sharp debridement of left heel 3 x 4 x 1 cm" + "sharp debridement of great toe" OP note states the same with great toe ulcer being 1 x 1.5 cm stage 3. Surgeon states "large necrotic pressure ulcer with associated eschar is sharply removed in the deep tissues."

- Cultures are obtained of the wound. Next, after the eschar and necrotic tissue are excised sharply using multiple scalpels, it is debrided down to the level of bleeding tissue.
- Bleeding is controlled with direct pressure and also with silver nitrate.
- The surgeon has clearly described excisional debridement and has used the terms "excised sharply using multiple scalpels;" and "removed" which would correlate with excisional debridement.
- The level of excisional debridement is down to bleeding tissue, which would not be the case with a nonexcisional debridement of loose necrotic skin or fragments. This patient had tissue excised sharply and removed down to bleeding tissue.

Please refer to *AHA Coding Clinic* 1Q 2008 page 3 and *Coding Clinic,* Second Quarter 2004 Page: 5, which describes that excisional debridement is the definite cutting away of tissue as opposed to the scraping of loose fragments from the area.

Enclosed is the copy of the medical record documents that support the above.

Based on the preceding information, we respectfully request a written response that results in a favorable decision for XYZ Hospital for assignment of DRG 622, Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC (RW 3.1728).

Please contact me at [phone number] or by e-mail [e-mail address] if you have any questions or need further clarification.

Sincerely,

[Reviewer's name]
[Reviewer's title]
Enclosures

APPENDIX K

ACRONYMS

ADR	additional documentation request
ALJ	administrative law judge
ASC	ambulatory surgical center
CAH	critical access hospital
CDI	clinical documentation improvement
CDT	continuing day treatment (providers)
CERT	Comprehensive Error Rate Testing (program)
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CMP	civil monetary penalty
COP	Conditions of Participation
CORF	comprehensive outpatient rehabilitation facility
CPG	compliance program guidance
CWF	common working file
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DRG	diagnosis-related group
DSH	disproportionate share hospital
E&M	evaluation and management (services)
EHR	electronic health records
FFS	fee-for-service (payments)
FI	fiscal intermediary
FY	fiscal year
HAC	hospital-acquired condition
HCBS	home- and community-based services
HCC	hierarchical condition categories
HCCN	health center controlled networks
HCPCS	Health Care Common Procedure Coding System
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	home health agency
HHRG	home health resource group
HIC	Medicare health insurance claim number
HIT	health information technology
HMO	health maintenance organization
HPMP	hospital payment monitoring program
IDTF	independent diagnostic testing facility
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPIA	Improper Payment Information Act of 2002
IPPS	inpatient prospective payment system
IRF	inpatient rehabilitation facility
LCD	local coverage determination
LTCH	long-term care hospital
MA	Medicare Advantage
MAC	Medicare administrative contractor
MAO	Medicare Advantage organization
MA-PD	Medicare Advantage prescription drug organization
MCE	Medicaid managed care entities
MCO	managed care organization
MDS	minimum data set
MEDIC	Medicare drug integrity contractor
MIC	Medicaid integrity contractors
MIP	Medicaid integrity program
MRN	medical record number
MSDRG	Medicare severity diagnosis-related group
MSN	Medicare summary notice
MSP	Medicare secondary payer
MSPRC	Medicare secondary payer recovery contractor
NCD	national coverage determination
NPI	national provider identifier
OASIS	outcome and assessment information set
OPPS	outpatient prospective payment system
PERM	Payment Error Rate Measurement (program)
PHI	protected health information
PHP	partial hospitalization program
POA	present on admission
PPS	prospective payment system
PSC	program safeguard contractor
QASP	quality assurance surveillance plan
QI	qualifying individual program
QIO	quality improvement organization
RA	remittance advice
RAC	recovery audit contractor
RADV	risk adjustment data validation
RAI	resident assessment instrument
RAS	recovery audit specialist
RUG	Resource Utilization Group
Rx-HCC	prescription drug model used for payment under Part D
SNF	skilled nursing facility
SNP	special needs plan
SOW	statement of work
SSN	Social Security number
TAG	technical advisory group
TPL	third-party liability
TrOOP	true out-of-pocket costs for Part D
UPIN	unique physician identifier number
WAMP	widely available market price
ZPIC	zone program integrity contractor

Organizations

CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Agency
DHS	Department of Homeland Security
DOD	Department of Defense
DOJ	Department of Justice
DOS	Department of State
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IRS	Internal Revenue Service
MFCU	State Medicaid Fraud Control Units
MedPAC	Medicare Payment Advisory Commission
NIH	National Institutes of Health
OAS	Office of Audit Services
OCIG	Office of Counsel to the Inspector General
OCR	Office for Civil Rights
OGE	Office of Government Ethics
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
ONDCP	Office of National Drug Control Policy
PSC	Program Support Center
VA	Department of Veterans Affairs

APPENDIX L

CMS FORMS 20027 AND 20030

These forms can be accessed at: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

Form CMS-20027 (12/10) DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM—FIRST LEVEL OF APPEAL

1. Beneficiary's name:_____

2. Medicare number: _____

3. Item or service you wish to appeal: _____

4. Date the service or item was received: _____

5. Date of the initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

    5a. Name of the Medicare contractor that made the determination (not required):

    5b. Does this appeal involve an overpayment? Yes No
    (for providers and suppliers only)

6. I do not agree with the determination decision on my claim because: _____

7. Additional information Medicare should consider: _____

8. I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

[ ] I do not have evidence to submit.

9. Person appealing: [ ] Beneficiary [ ]Provider/Supplier [ ] Representative

10. Name, address, and telephone number of person appealing: _____

11. Signature of person appealing: _____

12. Date signed:_____

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at cms.gov/PrivacyActSystemofRecords/downloads/0566.pdf

Form CMS-20033 (12/10)
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE AND MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM—SECOND LEVEL OF APPEAL

1. Beneficiary's name: _____

2. Medicare number: _____

3. Item or service you wish to appeal: _____

4. Date the service or item was received: _____

5. Date of the redetermination notice (please include a copy of the notice with this request): _____
(If you received your redetermination notice more than 180 days ago, include your reason for the late filing.)

   5a. Name of the Medicare contractor that made the redetermination (not required if copy of notice attached): _____

   5b. Does this appeal involve an overpayment? Yes No
   (for providers and suppliers only)

6. I do not agree with the redetermination decision on my claim because: _____

7. Additional information Medicare should consider: _____

8. I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration.

   [ ] I do not have evidence to submit.

9. Person appealing: [ ] Beneficiary [ ] Provider/Supplier [ ] Representative

10. Name, address, and telephone number of person appealing: _____

11. Signature of person appealing: _____

12. Date signed:_____

PRIVACY ACT STATEMENT: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at cms.gov/privacyactsystemofrecords/downloads/0566.pdf