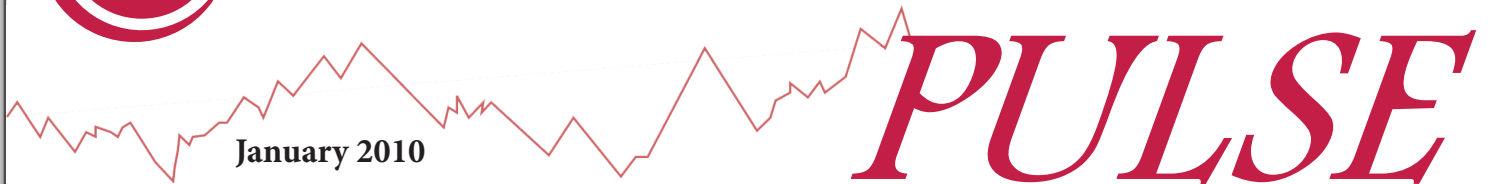




American Physicians Insurance Company



Is Your Practice Ready for RAC?

The Centers for Medicare and Medicaid Services (CMS) enacted the Recovery Audit Contractor (RAC) program in 2005 to recoup improper payments to healthcare providers. The goal of the recovery audit program is to identify improper payments made on claims of services provided to Medicare beneficiaries. The recouped funds are put back into the Medicare Trust Fund. Since inception, RAC auditors have recovered nearly \$1 billion. Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC program permanent and requires expansion into all 50 states by 2010. Auditors will review all claims submitted on or after October 1, 2007, to identify inappropriate payments. RAC auditors have systems in place to flag any claim in which an overpayment is likely to have occurred based on the billing data provided. There is clear incentive for RAC auditors to find inappropriate payments. The RAC contractors are allowed to keep 9 percent to 12.5 percent of overpayments. Providers susceptible to RAC audits include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment (DME) providers, and any other provider or supplier that submits claims to Medicare.

In the initial phase, RAC auditors focused on high dollar, low volume claims generated mostly from hospitals. With a broader rollout of the RAC program, physician practice audits are more likely to occur. Medicare reimbursement is immediately garnished once the auditor confirms any overpayment. RAC auditors find overpayments when there is a lack of proof of medical necessity. Without proper documentation there is no proof to prevent overpayment determinations. Improper payments on claims can include, but are not limited to:

- Payments made for services that were not medically necessary or did not meet CMS medical necessity criteria for the service rendered
- Payments made for services that are incorrectly coded
- Failure to submit sufficient documentation to support the claim
- Duplicate payment

Knowing what to expect is key. Providers must be ready to respond to audit requests, demand for repayment, review and analyze determinations by the RAC auditors and file appeals if necessary. These reviews require considerable resources and time to fulfill the RAC requests. Such demands could prove costly for small offices.

Auditors for the CMS RAC program have identified the 10 most common problems being uncovered in the audit process:

- Debridement Coding
- Duplicate Billing
- Stark Violations
- Pharmaceutical Coding in Physician Offices
- Social Work Services in Facilities
- Psychiatric Services
- Medical Necessity
- E/M Billed During Global Periods
- Place of Service Errors
- Incident to Errors

It is more critical than ever to review your current billing and compliance policies and procedures to ensure you comply with the regulations required by CMS so you can identify inconsistencies and take corrective action. Your office should review the list of common issues for RAC as identified in the pilot program.

Proactive strategies include:

- Perform a pre-audit to identify potential areas of risk
- Review historical claims history to identify any inconsistencies, incorrect coding or duplicate claims
- Conduct chart reviews to validate coding accuracy and documentation to determine if medical necessity criteria are present

(Continued on pg. 3)

API CASE ANALYSIS

ISSUE: DELAY IN DIAGNOSIS – CANCER

READ, RECORD, AND GO! FOR .5 CREDITS CAT II CME

Who

General Surgeon

What

A 41 year old female with a breast mass underwent a lumpectomy. The diagnosis was fibroadenoma and the patient was to be followed with serial visits and mammograms. During one of her post-procedure visits, she showed the surgeon a “dark freckle” on her forearm. The surgeon indicated he could remove it with liquid nitrogen, the patient agreed and the surgeon fulgerated the lesion.

Her medical history prior to treatment for the breast mass was very complicated. Although her history was complicated, her family history, as documented in her surgical record, was negative except for one aunt who had melanoma.

Six months after the lesion was removed by the surgeon, the patient saw the physician again for breast follow-up. There was no documentation of discussion or re-evaluation of the lesion removed at the prior visit. At some point in time, about six months after the lesion was originally removed (it is not clear if the redness was present during the 6 month breast check-up), there was a recurrence of the lesion on the patient’s forearm. The area had become reddened and over the next few months also became raised.

The patient then saw a dermatologist who performed a punch biopsy which confirmed a malignant melanoma, Clark’s level 5.

Why

The malignant melanoma was not diagnosed timely due to the failure of the surgeon to obtain tissue for biopsy prior to the removal of the lesion. In addition, the surgeon neglected to review the patient’s family history for this new problem, and failed to establish an adequate treatment plan including follow-up. The patient’s prognosis was poor due to the stage of the melanoma at the time it was properly diagnosed. At the time the case was settled, the patient had already undergone several procedures and was receiving adjuvant therapy. At the time of this publication, the patient’s condition or survival are not known.

When

During an office encounter

Where

Office

How

The physician failed to review the patient’s history form and perform a biopsy prior to fulgeration of the lesion.

Risk Management Thought for Prevention

According to standard of care and expert testimony, a biopsy should have been performed by the surgeon prior to removal of the lesion for pathological confirmation of tissue type and to rule out a cancerous lesion. Other weaknesses are failure to biopsy the skin lesion in this patient with a family history of malignant melanoma and failure to follow-up at the next visit with the patient. When the standard of care is not followed, the physician’s rationale for deviation from that standard should be clearly documented. Recommendation for biopsy was the surgeon’s responsibility, unless the patient refused to cooperate at which point the refusal should have been documented. According to another expert, almost 100% of skin melanomas under the diameter of 1 cm can be cured by a simple excisional biopsy if the depth level is 1 or 2. No defense experts were identified in this case. If the diagnosis had been made at the time the original lesion was removed, the patient’s chance of cure and survival would have been dramatically improved.

If you wish to request .5 Category I CME Credits related to either Case Analysis...

Go to www.api-c.com. The full Case Analysis including a post-test and evaluation are under Risk Management Institute. Upon successful completion of the post-test and receipt of the evaluation, physicians may receive up to .5 category I CME Credits.

Accreditation: American Physicians Insurance Company is accredited by Texas Medical Association to provide continuing medical education for physicians.

API CASE ANALYSIS

ISSUE: PATIENT ABANDONMENT – CALL COVERAGE

READ, RECORD, AND GO! FOR .5 CREDITS CAT II CME

Who

General Surgeon
Internist – On Call Physician
Consulting Surgeon

What

A 60 year old male was admitted by his family physician for a pulsatile abdominal mass. A general surgeon was immediately involved with the case and a CT scan was ordered. The results of the CT scan confirmed a leaking abdominal aortic aneurysm and the patient was taken to surgery. The operative note documented good flow into the left leg but there were no palpable pulses in the right leg. About 6 hours after the surgery, the patient began complaining of pain in his right foot. The patient was returned to surgery for a second procedure. At this point the patient underwent a femoral embolectomy, arteriogram, and an external iliac femoral bypass with gortex. The first post-op day the nurses document the patient's leg as being mottled up to the calf. The patient was started on heparin and a 3rd procedure was done. About three days after the 3rd procedure, the patient began having coffee ground drainage from the nasogastric tube and the heparin was stopped. The vascular status of the patient's extremities was stable at that point.

Fast forward one week. The patient has a catastrophic complication and treatment is not available at the hospital he is in. The patient is transferred via helicopter to a tertiary care facility and ultimately ends up with a disarticulation at the hip.

Why

Six days after the third procedure, the surgeon had to leave town for a few hours and arranged for coverage. The hospital was located in a small rural town, so vascular coverage was not available, but as the physician stated, he only planned to be gone for a few hours. As Murphy's Law would have it, this is the day the next complication occurred. The physician who had agreed to cover for the surgeon was not of the same specialty, he was an internist, not a surgeon.

On this day the patient had a pulseless, pale and painful leg indicating an acute vascular problem. The nurses contacted the internist on call for the surgeon. The on-call physician then attempted to reach the surgeon to no avail as he was out of the area. A call was then placed to another surgeon who had consulted on the case (physician-patient relationship was established). This surgeon was over 1 ½ hours away and felt the regular surgeon would be able to reach the patient sooner. The consultant surgeon recommended some interim measures for the on-call physician to take while they continued to try and reach the patient's surgeon. At that point, the decision was made to transfer the patient to a larger city where vascular surgeons were available to try and save the patient's limb. The patient underwent a guillotine amputation, then hip disarticulation, and later skin grafting.

When

Post-operative hospital stay

Where

Hospital

How

During transition of call-coverage, the on-call physician was not made aware of the surgical nature of the patient he was accepting a call for.

Risk Management Thought for Prevention

Although coverage arrangements were made by the surgeon for the time he was to be out of town, the coverage was not adequate according to expert review. In addition, the on-call physician indicated he would not have accepted call for the surgeon if he had truly been informed of the condition of the patient and nature of his on-going problems. Communication for call coverage and during transition is critical. All parties involved should clearly understand the situation they are transferring, as well as accepting.

Is Your Practice Ready for RAC?

(Continued from pg. 1)

Providers, compliance officers and billing staff must continue to educate themselves on coding and documentation as part of the expanding compliance focus of CMS. There are a multitude of RAC resources and management solutions available online to help providers prepare for and manage a RAC audit. Involvement of legal counsel in the RAC process should also be considered.

American Physicians Insurance Company offers you, as part of your policy, a \$100,000 for legal expense reimbursement (including fines and penalties) for state and federal disciplinary actions, EMTALA and HIPAA violations, and Medicare/Medicaid fraud and abuse claims. This coverage extends to RAC audits. You may purchase additional coverage up to \$1,000,000 total. To do so, or if you have any questions, please contact your Underwriter or Heather Spicer, Vice President of Underwriting, at 800.252.3628, ext. 4312.

STEPHANIE DUGGAN, CPC, CPHRM
RISK MANAGER
SDUGGAN@API-C.COM

Bariatric Surgery

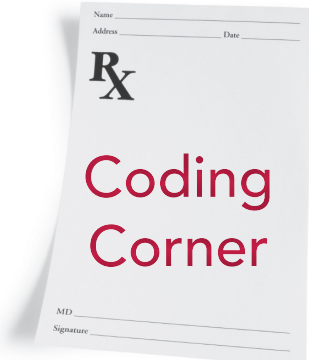
Obesity is the second leading cause of premature death in the U.S. according to the Journal of the American Medical Association (JAMA). This serious medical condition affects more than 60% of the U.S. population and costs 6% of U.S. healthcare expenditures per year.

Bariatric weight loss surgery has become an increasingly popular option to correct morbid obesity and induce rapid weight loss.

Coding options depend on the type of procedure performed.

- 43770 – Laparoscopy, surgical, gastric restrictive procedure, is the placement of an adjustable gastric restrictive device (e.g., Gastric band and subcutaneous port components) is the proper code of choice for the Lap-Band procedure.
- 43846 – Gastric restrictive procedure, with gastric bypass for morbid obesity with short limb (150 cm or less) Roux-en-Y gastroenterostomy for greater than 150 cm use 43847) should be used for traditional gastric bypass.
- 43644 – Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) should be used for laparoscopic bypass surgery.

STEPHANIE DUGGAN, CPC, CPHRM
RISK MANAGER
SDUGGAN@API-C.COM



ePulse Subscription

In November 2009, the API Risk Management Institute launched the API ePulse Newsletter, an electronic version of the Pulse. The publication is sent bi-monthly via e-mail and provides two case analyses for CME, useful news, tips and healthcare trends. With this launch, the monthly API Case Analysis was replaced by the ePulse and offers the same amount of CME credits each year. API is at the forefront of protecting physicians and their practices and we are pleased to offer this wealth of valuable information as part of our dedication to you.

To view the ePulse archive, visit www.api-c.com, click on Risk Management Institute and then ePulse Newsletter.

Subscribe now!
To transfer your subscription of
the Pulse to the ePulse,
e-mail ePulse@api-c.com today!

New Legislative Requirements: SIDS and Sickle Cell

To see the full article, please go to
www.api-c.com. The article is listed under Risk
Management Resources, then under Hot Topics.

© 2009 American Physicians Insurance Company. All rights reserved.

Disclaimer: The PULSE newsletter is published by American Physicians Insurance Company. Articles and other content appearing in the PULSE newsletter are for informational purposes only. The contents are not intended to represent the "standard of care" for the practice of medicine, or to be regarded as legal advice, and readers should not rely upon this information. If legal, medical or other professional advice is required, the services of a competent professional person should be sought. American Physicians Insurance Company and its subsidiaries and affiliates expressly disclaim all liability in respect to actions taken or not taken based on any or all the contents of this newsletter.

api

Presorted
Standard
U.S. Postage
PAID
Austin, TX
Permit No. 272

American Physicians Insurance Company
1301 S. Capital of Texas Highway, Suite C-300
Austin, Texas 78746

