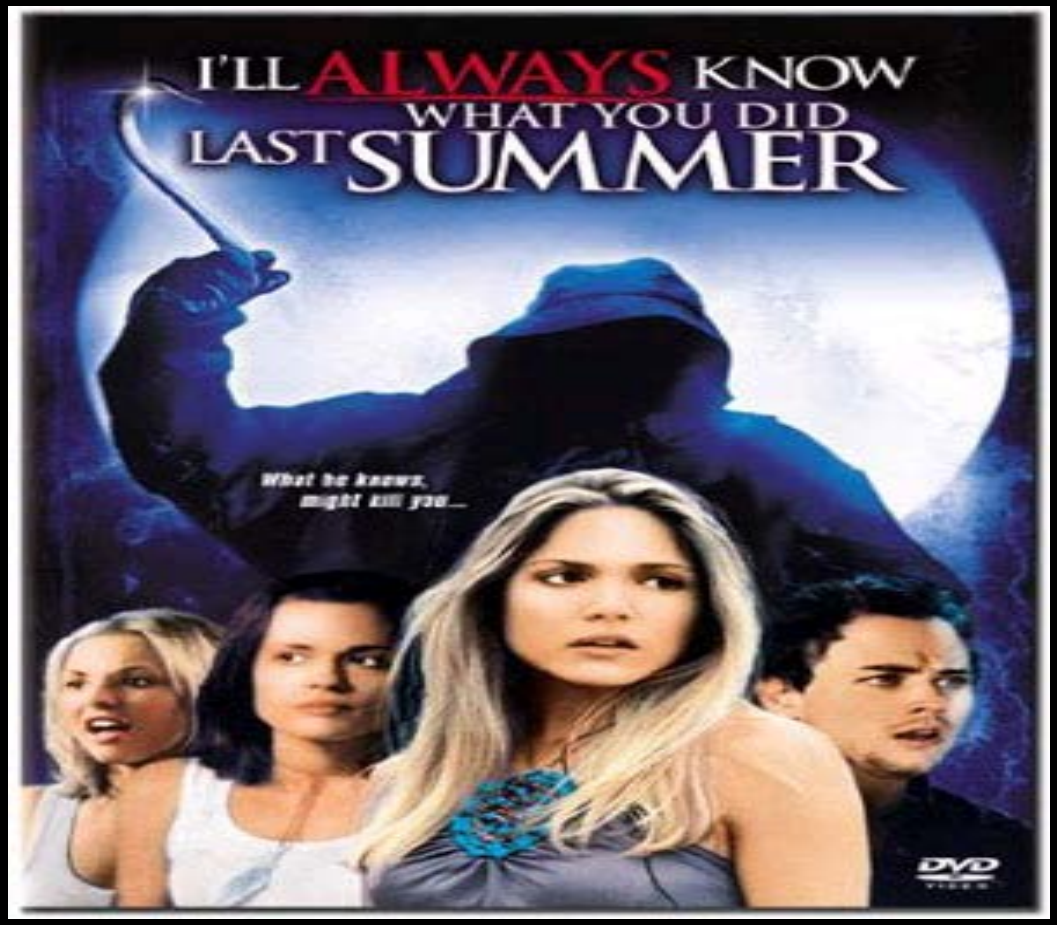


Is someone coming to get your money?

InRich ADVISORS

Staying Paid:

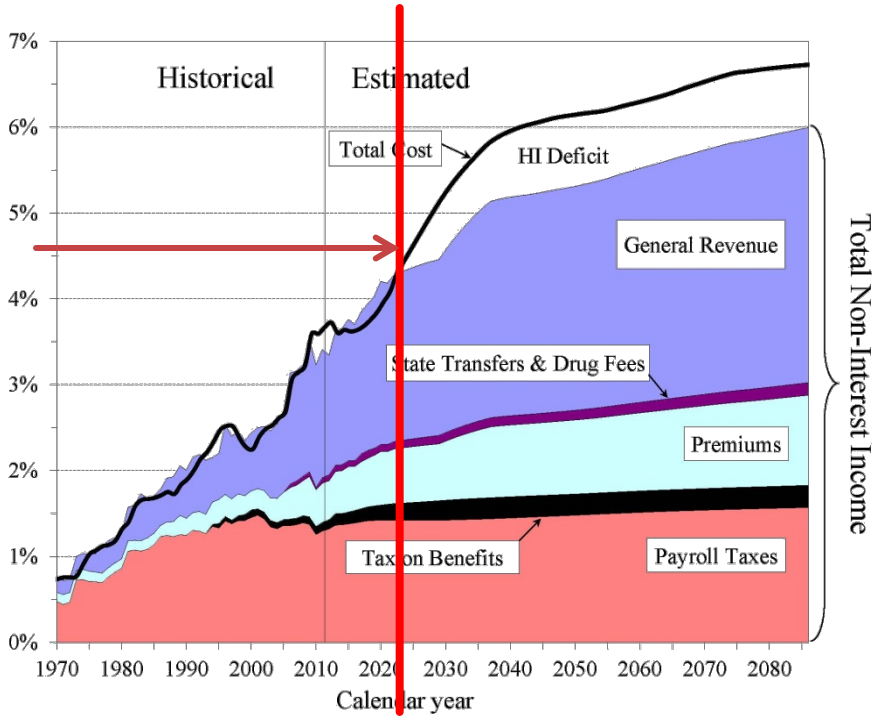
Does your documentation give "voice" to the claim?

Office of Inspector General (OIG)

- Fighting fraud and abuse in Medicare and Medicaid is the job of the OIG, which is responsible for policing all Health and Human Services (HHS) agencies, including Medicare (CMS).
- One of their main responsibilities is conducting and supervising audits, investigations, inspections and evaluations on CMS programs.

Impending Medicare Bankruptcy

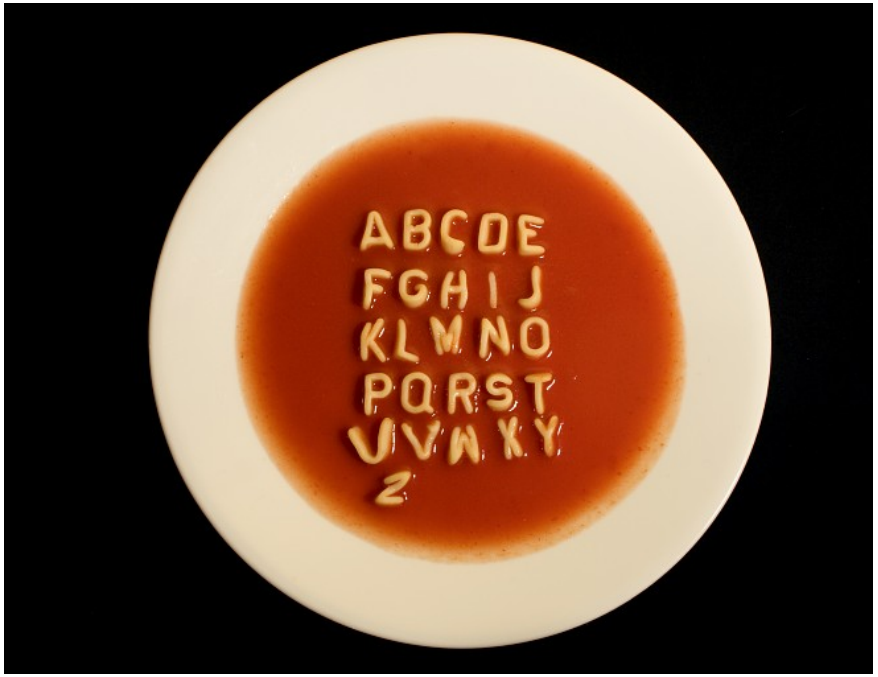
- Medicare will go bankrupt in either 2024 or 2016, depending on how you calculate the effect of Obamacare (2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds).
- Improper payments are a significant contributor to this problem.
  - >30% of Medicare payments are "improper"



Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

Coming for the Money . . . alphabet soup of auditing agencies!

- RACs, ZPICs, CERTs, SIUs, etc.
- Not a matter of if…it's a matter of when!



RAC Auditors

- RAC: Recovery Audit Contractors
- Mission: reduce Medicare improper payments (over or underpayments)
- Work on commission
  - Receive 9% - 12.5% of everything they *collect*
  - Can go back as far as 36 months
- Use proprietary software programs to identify potential payment errors (e.g. duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding)

The original "rack" auditor (which might have been easier)

How do the RACs Find the Money?

- Look for statistical anomalies
- It is imperative that you know not only whether you can justify your billed level of service, **but whether the distribution of your charges falls in an acceptable range from a statistical standpoint**
  - From March 2005-March 2008, the RACs corrected more than $1.03 billion in Medicare improper payments.

Reasons for Recoupment for "Improper Payments" by the RAC

1. Services that did not meet Medicare's ***medical necessity*** criteria (e.g. therapy sessions that were excessive).
2. Services ***coded incorrectly*** (e.g. principal diagnosis on the claim did not match principal diagnosis on the medical records).
3. Failure to support claims with ***proper medical documentation*** (e.g. medical records did not describe adequately the procedures reported on the claim).
4. Submittal of claims to Medicare that should have been submitted to another insurer.
5. Other reasons (e.g. submitting duplicate claims or using outdated fee schedules).

Documentation is KEY to hanging on to your $$!

- The medical record itself should read like a story telling about the patient and how you cared for that patient.
- A good medical record gives the reader, ***perhaps even years down the road,*** an understanding of the thought process that went into the decision-making and ultimately the treatment of the patient.

Documentation and the Absent Minded Professor

"I'm a good doctor, I just don't like the paperwork"

“The OIG finds that excuse neither charming nor persuasive”!

Chief Medical Officer OIG/HHS

How to Establish Medical Necessity for HBOT: Option # 1

- 707.X related to Diabetes (280)
- Start HBOT 2.0 ATA x 30 treatments

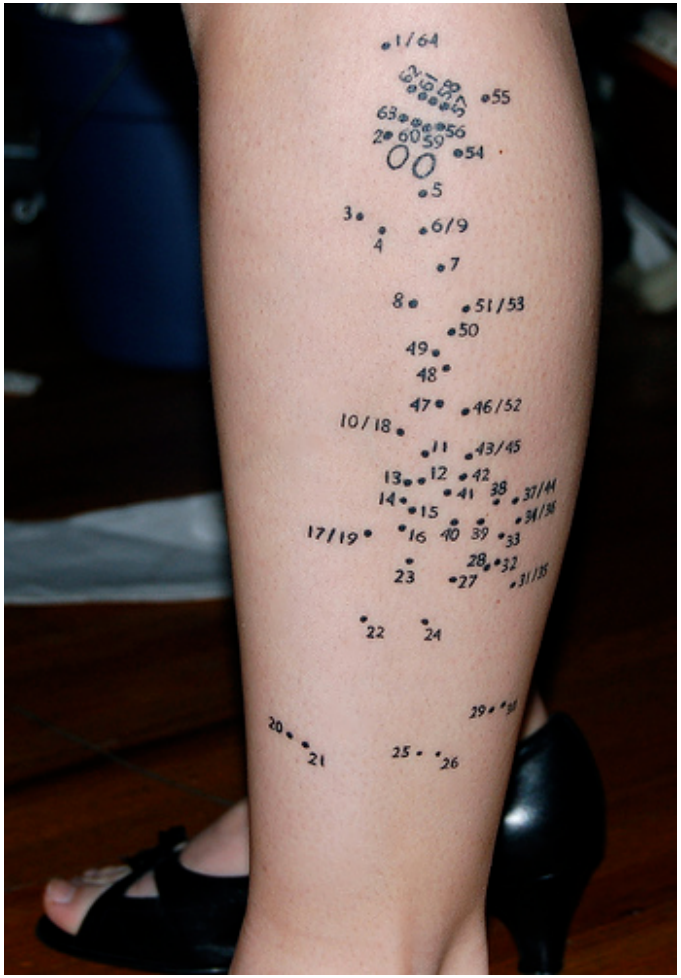
That was easy. What is wrong with that?

How to Establish Medical Necessity for HBOT: Option #2

Paste this into your EHR (EHRs are GREAT for this purpose, saves typing!):
"Hyperbaric oxygen therapy is the administration of oxygen at greater than sea level pressure. It has been shown to increase tissue PO2 and enhance vascularity among patients with ischemic diabetic foot ulcers. Pooled data from 3 trials with 118 patients showed a reduction in the risk of major amputation when adjunctive HBOT was used, compared to the alternative therapy (RR: 0.31; 95%-CI 0.13 to 0.71). Both BCBS and the ADA have concluded that there is sufficient evidence to support the use of adjunctive HBOT in the treatment of adequately perfused chronic non-healing wounds of the lower extremity."
This patient has a Wagner III Diabetic foot ulcer and needs HBOT.

Thank goodness for EHRs! What's wrong with that?

Indication vs. Medical Necessity



Documenting diagnosis (ICD-9) alone is not enough to reveal the big picture!

You need to Connect the Dots!

- Review the facts—describe the patient's history in light of the specific coverage policy requirements.
- **Tell the story** (Connect the dots)
  - Detail how ***THIS PARTICULAR PATIENT*** meets the coverage indication by having failed 30 days of care **including** revascularization, infection control, nutrition control, off-loading, etc**.**

How to Establish Medical Necessity for HBOT: Option #3

- **Gather the evidence, and MAKE THE CASE**
  - Support the ICD-9 code you provided with further documentation if necessary (e.g. MRI), exam findings.

You have to MAKE THE CASE FOR EACH PATIENT at EVERY ENCOUNTER!

Conflicting documentation as bad as no documentation!

Conflicting documentation between assessment and debridement details.

Plantar *Heel*

Wound Measurements	
Length: (cm)	2.4
Width: (cm)	2.4
Depth: (cm)	0.5
Hypergranulated:	No
Area: (sq cm) based on n*(L*W)/4	4.52
Volume: (cm^3) based on Area*D	2.26

Wound Margin:	Thickened and Rolled Under
	Percentage
Adherent Yellow Slough:	26-50%
Moist Yellow Slough:	None
Dry Black Eschar:	None
Moist Black Eschar:	None
Epithelialization:	26-50%
Granulation:	26-50%
Pink:	Yes

Debridement Details

Patient Name: [redacted]
Patient Number:
Patient Date of Birth: 1/8/1948
Patient Account Number:

Date: 2/17/2011
Clinician:
Physician / Extender: [redacted]

Debridement Performed for Assessment:	Wound #6 Right,Plantar Heel
Performed By:	Physician [redacted]
Debridement:	Excisional
Time-Out Taken:	Yes
Pain Control:	2% Lido
Level:	Skin/Sub/Tiss/Musc
Area (sq cm):	4.52
Tissue and other material debrided:	Necrotic/Eschar, Fibrin, Exudate, Other, Skin, Subcutaneous, Slough
Instrument:	Curette
Bleeding:	Moderate
Hemostasis Achieved:	Pressure
Procedural Pain:	4
Post Procedural Pain:	1
Response to Treatment:	Procedure was tolerated well

Notes

C&S SENT

Electronic Signature(s)

Signed By: [redacted]

Date:
02/17/2011 11:00:48 AM
02/17/2011 11:11:07 AM
02/17/2011 11:33:28 AM

No narrative of procedure.

Four months and 8 more *muscle* debridements billed later…

Wound Measurements

Length: (cm)	1.6
Width: (cm)	1.2
Depth: (cm)	1.3
Hypergranulated:	No
Area: (sq cm) based on n*(L*W)/4	1.508
Volume: (cm^3) based on Area*D	1.96

Wound Description

Wound Progress:	Improving
Wagner Scale:	Grade 2
Exudate Amount:	Moderate
Exudate Type:	Sero-sanguineous
Odor:	None
Pain:	0
Wound Margin:	Thickened

	Percentage
Adherent Yellow Slough:	1-25%
Moist Yellow Slough:	None
Dry Black Eschar:	None
Moist Black Eschar:	None
Granulation:	76-100%
Pale Grey:	Yes
Pink:	Yes

Debridement Details

Patient Name: [redacted]
Patient Number:
Patient Date of Birth:
Patient Account Number:

Date: 6/2/2011
Clinician:
Physician / Extender: [redacted]

Debridement Performed for Assessment:	Wound #6 Right,Plantar Heel
Performed By:	Physician [redacted]
Debridement:	Excisional
Time-Out Taken:	Yes
Pain Control:	2% Lido
Level:	Skin/Sub/Tiss/Musc
Area (sq cm):	1.51
Tissue and other material debrided:	Fibrin, Muscle, Exudate, Subcutaneous, Slough
Instrument:	Curette
Bleeding:	Moderate
Hemostasis Achieved:	Pressure
Procedural Pain:	0
Post Procedural Pain:	0
Response to Treatment:	Procedure was tolerated well

Electronic Signature(s)

Signed By: [redacted]

Date:
06/02/2011 11:42:04 AM

Entered By: [redacted] on 06/02/2011 11:24:20 AM

No narrative of procedure.

Payer Utilization Guidelines

- Exceeding quantity limitations set forth by payer policies can lead to denials and/or recoupment as not "reasonable and necessary".
- Recent **In*Rich*** audit: Patient reviewed had been in service for 12 months with a mastectomy wound having received 39 muscle debridement's on the same wound!

Quantity of data in Medical Record is GROWING.

- In order to meet payer requirements for documentation requirements, no longer possible for clinicians to rely on memory alone.
- Tracking Utilization caps
- Advanced Beneficiary of Notice (ABN)

In Conclusion:

"Humans. You're not worth the flesh you're printed on!"

Quote from Tales of the Crypt

Outpatient Auditing Group

toni@in*rich*advisors.com

Disclaimer

The analysis of any medical billing or coding question is dependent on numerous specific facts — including the factual situations present related to the patients, the practice, the professionals and the medical services and advice.

Additionally, laws and regulations and insurance and payer policies (as well as coding itself) are subject to change. The information that has been accurate previously can be particularly dependent on changes in time or circumstances. The information contained in this presentation is intended as general information only.