

July 16, 2008

MEDICARE RECOVERY AUDIT CONTRACTORS (RACs): CODING & DOCUMENTATION STRATEGIES

AT A GLANCE

The Issue:

The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. The Centers for Medicare & Medicaid Services (CMS) recently reported that RACs collected \$992.7 million in overpayments during the three-year RAC demonstration, with more than 96 percent of these funds collected from hospitals in a limited number of states. Thirty-five percent of RAC denials were due to incorrect coding, while another 8 percent were due to insufficient or no documentation.

Our Take:

Since coding and documentation errors accounted for nearly half (43 percent) of RAC demonstration denials, we anticipate that these types of errors will be targeted by the permanent RACs, and encourage you to focus on these particular types of errors in your preparations for the national RAC rollout. The AHA has many concerns about the RAC program and is working with CMS and Congress to improve RAC oversight and fairness. Still, it is important for hospitals to prepare, as hospitals have a valuable opportunity to proactively ensure the accuracy of their documentation and coding practices to reduce the risk of significant RAC denials.

What You Can Do:

This advisory highlights the types of coding issues targeted during the RAC demonstration and strategies your organization can implement to reduce the impact of RAC audits. It also outlines steps your hospital can take to improve medical record documentation.

This information is provided only as a guideline. Consult with legal counsel and your financial and coding experts before finalizing any policy or practice.

Please share this advisory with the following key staff:

- Your executive, medical and financial leaders, and legal counsel;
- Your RAC team, which should include physicians, nurses, case managers and others making clinical decisions on documentation; and
- Coding, billing and documentation specialists, as well as medical records/health information management staff.

Further Questions:

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BACKGROUND

The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments – to providers. Following a three-year RAC demonstration, which ended March 2008, the Centers for Medicare & Medicaid Services (CMS) plans to expand the program nationwide through a three-stage process, with 19 states coming under RAC review this summer, followed by five states in the fall, and the remaining states beginning in 2009. (A map of the projected roll-out dates is available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>.) RACs will review claims that are up to three years old, but in no case may review claims paid prior to October 1, 2007. Therefore, it is imperative that hospitals do everything possible to prepare for RAC review to avoid potentially disruptive claims denials.

CMS recently reported that RACs collected \$992.7 million in overpayments from Medicare providers during the RAC demonstration, with more than 96 percent of these funds collected from hospitals. Thirty-five percent of denials were due to incorrectly coded claims and 8 percent were for insufficient or no documentation. To minimize coding and documentation denials, hospitals must ensure that key staff understand the importance of accurate clinical coding and provide staff with necessary resources, such as the most recent coding guidelines for the areas targeted by the demonstration RACs.

During the demonstration, each of the three RACs had the autonomy to unilaterally identify the types of claims and errors they targeted. The following coding areas were targeted by one or more RACs during the demonstration and are addressed in greater detail below:

- Debridement (excisional vs. nonexcisional);
- Incorrect selection of principal diagnosis (respiratory failure vs. sepsis);
- Wrong diagnosis code (sepsis, septicemia vs. urosepsis);
- Diagnosis-related groups (DRGs) designated as complicated or having comorbidity with only one secondary diagnosis (DRGs 079, 416, 468, 475, 477 and 483); and
- Unit of service (multiple colonoscopies for the same beneficiary on the same day; Neulasta, 1 unit per vial vs. 1 unit per milligram of drug delivered).

We anticipate that these coding areas will be among the early targets for the national RAC program, although CMS has indicated that it will have more oversight of the types of audits selected by the new permanent RACs.

AT ISSUE

Coding and Documentation Recommendations

The following strategies will help your hospital ensure accurate coding and medical record documentation. An emphasis on both documentation and coding is critical to minimize your risk for RAC denials. Without consistent and complete documentation in the medical record, accurate coding cannot be achieved. While your hospital already may have many of the processes below in place, given the high rate of RAC demonstration denials for documentation and coding errors, we encourage you to revisit your policies and practices to help reduce your hospital's RAC denials.

- Examine your clinical documentation protocols to identify areas for improvement.
 - Provider documentation must support every coding assignment. Per the coding guidelines, “provider” means physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.
 - Review and refine your process for identifying potential gaps in each record’s documentation that may require additional physician specificity.
 - Review and refine your physician query process according to the do’s and don’ts developed by the American Health Information Management Association (AHIMA)¹, which provide guidelines on obtaining physician clarification on missing information or inconsistent documentation.
 - Review coding and documentation guidelines with outside consultants and vendors to stress the importance of the accuracy and integrity of medical record documentation and coding.
 - Review your charge description master (CDM) and ensure that the unit of service for HCPCS codes is correctly identified (e.g., grams vs. milligrams).
- Work with your physicians, nurses and other clinicians to ensure a consistent and collaborative approach on your hospital’s coding and documentation protocols.
 - Develop and periodically update facility-specific coding guidelines that promote the complete documentation needed for consistent code assignment.
 - Develop guidelines to clarify when coding professionals should query physicians for clarification of their documentation.
 - Emphasize that coding guidelines must be applied to all records.
 - Emphasize that facility-specific coding guidelines do not replace the need for provider documentation.

¹ Physician query “do’s and don’ts” are included in the AHIMA document “Practice Brief: Developing a Physician Query Process,” available at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_009224.hcsp?dDocName=bok1_009224.

- Provide adequate resources and support for your coding professionals.
 - Provide current changes, coding advice and official coding guidelines to ensure correct code selection based on the rules applicable at the time of discharge.
 - Provide the following reference tools:
 - *Official Guidelines for Coding and Reporting.*
 - Current coding references (ICD-9-CM, CPT, HCPCS coding manuals or encoder).
 - *AHA Coding Clinic for ICD-9-CM.*
 - *AHA Coding Clinic for HCPCS.*
 - *CPT Assistant.*
 - Be sure coders and medical staff are familiar with the definitions of principal diagnosis and secondary diagnoses.
 - Conduct periodic meetings to review problem documentation areas, staff resources and determine whether revisions to Physician Query Forms are needed to streamline the process.
 - Provide regular training and continuing education for coders.
- RAC-specific recommendations:
 - Develop an internal tracking system to track all RAC communications and monitor the status of RAC record requests, records submitted for review, audit outcomes, and appeals activity.
 - Select a RAC coordinator to manage all RAC inquiries, coordinate evaluation of all medical records sent out for RAC review, and document and track all RAC communication.
 - Educate staff (i.e., clinicians, HIM coders, billers, financial managers, clinical documentation specialists, etc.) about the RAC.
 - Conduct internal (retrospective) coding audits to uncover potential problem areas.
 - Identify a process for reviewing RAC coding denials to determine validity of RAC denials.
 - Implement additional training of coders in RAC target areas.
 - Determine a process for appealing inappropriate RAC coding and documentation denials.

Recommendations for Coding Professionals

The following recommendations are intended for hospital personnel conducting medical record coding.

- The entire medical record should be reviewed to determine the specific reason for the encounter and the conditions treated.
- Abnormal findings (laboratory, X-ray, pathologic and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance.

- Do not assign diagnosis codes based on a patient's signs or symptoms without confirmation from the provider.
- Suspected "probable," "possible" and "rule out" diagnoses are coded as present for inpatient admissions, but only if the diagnosis is still not ruled out at the time of discharge.
- Assign codes for all diagnoses meeting the criteria for reportable diagnoses as identified in the *Official Guidelines for Coding and Reporting*.
- Keep current with changes in codes, coding advice and official coding guidelines to ensure correct code selection based on the rules applicable at the time of discharge.

Coding Clinic Guidelines for Codes Targeted during RAC Demonstration

Debridement. Many claims that were coded as excisional debridement (86.22) were denied during the RAC demonstration due to insufficient documentation regarding the type of debridement performed (excisional vs. nonexcisional), or due to code selection based on documentation available (e.g., sharp debridement coded as excisional debridement). Many of these denials were appealed by hospitals during the demonstration program and many cases are still unresolved. However, additional review of the following guidelines is important to ensure your hospital is coding correctly.

- Debridement of Amputation Site, *Coding Clinic*, First Quarter 2005 Page: 14.
- Debridement of amputation stump, *Coding Clinic*, Second Quarter 1998 Page: 15.
- Debridement of open fracture with fixation and shortening, *Coding Clinic*, Third Quarter 1995 Page: 12.
- Debridement of wound, excisional vs. nonexcisional – *Coding Clinic*, Fourth Quarter 1988.
- Escharotomy, *Coding Clinic*, Fourth Quarter 2000 Page: 68.
- Excisional Debridement, *Coding Clinic*, First Quarter 2008 Pages: 3 – 4.
- Excisional Debridement, *Coding Clinic*, Fourth Quarter 2004 Page: 138.
- Excisional Debridement of Other Sites, *Coding Clinic*, Second Quarter 2005 Pages: 3 – 4.
- Excisional debridement of wound, *Coding Clinic*, Second Quarter 2000 Page: 9.
- Excisional vs. nonexcisional debridement – guideline, *Coding Clinic*, Third Quarter 1991 Pages: 18 – 19.
- Extensive wound debridement, *Coding Clinic*, First Quarter 1999 Pages: 8 – 9.
- Laser debridement of ulcer down to bone w/skin flap closure, *Coding Clinic*, Second Quarter 1992 Page: 17.
- Laser debridement of wound down to bone, *Coding Clinic*, Third Quarter 1989 Page: 16.
- Nonsurgical Mechanical Debridement, *Coding Clinic*, Second Quarter 2004 Page: 6.
- Oasis (TM) wound dressing, *Coding Clinic*, Third Quarter 2002 Page: 23.
- Sharp Debridement Versus Excisional Debridement, *Coding Clinic*, Second Quarter 2004 Page: 5.
- Vacuum Assisted Closure (VAC), *Coding Clinic*, Third Quarter 2006 Pages: 19 – 20.

Sepsis, septicemia. During the RAC demonstration, many sepsis claims were denied because of incorrect sequencing of codes or insufficient documentation to support the diagnosis of sepsis. It is important to note that there are two different codes for urosepsis, and code selection should reflect the patient's condition and care, as documented in the medical record. For example, documentation supported urosepsis, meaning urinary tract infection (a localized infection), but the claim was coded for urosepsis meaning sepsis (systemic infection).

- *Official Guidelines for Coding and Reporting*, Section I, C, 1, b.
- Bacteremia – guidelines, *Coding Clinic*, Fourth Quarter 1993 Pages: 29 – 30.
- Bacteremia vs. septicemia, *Coding Clinic*, Second Quarter 2000 Page: 5.
- Biliary sepsis due to percutaneous transhepatic cholangiogram, *Coding Clinic*, Second Quarter 1995.
- Changes to the Official Guidelines for Coding and Reporting, *Coding Clinic*, Fourth Quarter 2003 Pages: 113 – 115.
- Clarification - Sepsis Due to Vascular Catheter, *Coding Clinic*, Second Quarter 2004 Page: 16.
- Clinical evidence of septicemia, *Coding Clinic*, Second Quarter 2000 Page: 3.
- Infection Due to Vascular Catheter, *Coding Clinic*, Fourth Quarter 2007 Pages: 96 – 97.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic*, Fourth Quarter 2007 Pages: 142 – 151.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic*, Fourth Quarter 2006 Pages 152 – 160.
- Influenza, Pneumonia, Septic Shock and Multi-Organ Failure, *Coding Clinic*, Second Quarter 2005.
- Nadir sepsis, *Coding Clinic*, Third Quarter 1996 Page: 16.
- Neutropenic sepsis, *Coding Clinic*, Second Quarter 1996 Page: 6.
- Sepsis syndrome, *Coding Clinic*, Second Quarter 2000 Pages: 3 – 4.
- Septic shock, *Coding Clinic*, Fourth Quarter 2003 Page: 7.
- Septic Shock, Respiratory Failure and Pneumonia, *Coding Clinic*, Second Quarter 2005 Pages: 19 – 20.
- Septicemia and septic shock – guidelines, *Coding Clinic*, First Quarter 1988.
- Septicemia diagnosis with negative blood cultures, *Coding Clinic*, Third Quarter 1988.
- Septicemia due to candida albicans, *Coding Clinic*, Second Quarter 1989 Page: 10.
- Septicemia due to staphylococcus, *Coding Clinic*, Fourth Quarter 1997 Page: 32.
- Septicemia due to vascular access device (VAD), *Coding Clinic*, Second Quarter 1994 Page: 13.
- Septicemia with negative blood cultures, *Coding Clinic*, Second Quarter 2000 Page: 5.
- Septicemia, SIRS, sepsis, severe sepsis and septic shock, *Coding Clinic*, Fourth Quarter 2003 Pages: 79 – 81.

- Systemic inflammatory response syndrome, *Coding Clinic*, Fourth Quarter 2002 Pages: 71 – 73.
- Urosepsis, *Coding Clinic*, First Quarter 1998 Page: 5.
- Urosepsis, organ specific sepsis, *Coding Clinic*, Second Quarter 2000 Page: 6.

Urosepsis. Some claims were denied by RACs because documentation in the record supported urosepsis, meaning urinary tract infection, but the Medicare claim was coded for urosepsis, meaning sepsis (systemic infection).

- *Official Guidelines for Coding and Reporting*, Section I, C, 1, b.
- Infectious and Parasitic Diseases, *Coding Clinic*, First Quarter 2006 Pages: 34 – 40.
- Infectious and Parasitic Diseases, *Coding Clinic*, First Quarter 2005 Pages: 34 – 40.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic*, Fourth Quarter 2007 Pages: 142 – 151.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic*, Fourth Quarter 2006 Pages 152 – 160.
- Septicemia, SIRS, sepsis, severe sepsis and septic shock, *Coding Clinic*, Fourth Quarter 2003 Pages: 79 – 81.
- Urosepsis, *Coding Clinic*, First Quarter 1998 Page: 5.
- Urosepsis, *Coding Clinic*, Second Quarter 2004 Page: 13.
- Urosepsis, organ specific sepsis, *Coding Clinic*, Second Quarter 2000 Page: 6.

Respiratory Failure. Some claims were denied for incorrect sequencing of principal diagnosis – respiratory failure vs. sepsis.

- *Official Guidelines for Coding and Reporting*, Section I, C, 1, b.
- *Official Guidelines for Coding and Reporting*, Section I, C, 8, c.
- Acute Respiratory Failure and Myasthenia Gravis, *Coding Clinic*, Fourth Quarter 2004 Page: 139.
- Acute respiratory failure due to mycoplasma pneumonia, *Coding Clinic*, November - December 1987 Pages: 5 – 6.
- Acute Respiratory Failure Due to Poisoning, *Coding Clinic*, Third Quarter 2007 Pages: 7 – 8.
- Burns and Respiratory Failure Due to Smoke Inhalation, *Coding Clinic*, Third Quarter 2005 Pages: 10 – 11.
- Carcinoma of the oropharynx with impending respiratory failure, *Coding Clinic*, Second Quarter 2002 Page: 6.
- Clarify - respiratory failure with respiratory conditions, *Coding Clinic*, Second Quarter 2000 Page: 21.
- Crack overdose with respiratory failure, *Coding Clinic*, First Quarter 1993 Page: 25.
- Diseases of Respiratory System, *Coding Clinic*, Fourth Quarter 2006 Pages 177 – 179.

- Diseases of Respiratory System (460-519), *Coding Clinic*, Fourth Quarter 2007 Pages: 167 – 170.
- Hypoxemia with Pneumonia and/or Respiratory Failure, *Coding Clinic*, Second Quarter 2006 Pages: 24 – 25.
- Respiratory Failure, *Coding Clinic*, First Quarter 2005 Pages: 3 – 8.
- Respiratory failure – acute or chronic, *Coding Clinic*, Fourth Quarter 1998 Page: 41.
- Respiratory failure – blood gas measurement, *Coding Clinic*, Second Quarter 1990 Pages: 20 – 21.
- Respiratory failure – clarification, *Coding Clinic*, Second Quarter 2003 Pages: 21 – 22.
- Respiratory failure – guidelines, *Coding Clinic*, September – October 1987.
- Respiratory failure – guidelines, *Coding Clinic*, Third Quarter 1988 Page: 7.
- Respiratory failure due to Pneumocystis carinii due to AIDS, *Coding Clinic*, First Quarter 2003 Page: 15.
- Respiratory failure due to poisoning – sequencing, *Coding Clinic*, Third Quarter 1991 Page: 14.
- Respiratory failure w/ nonrespiratory conditions – guidelines, *Coding Clinic*, Second Quarter 1991 Pages: 3 – 5.
- Septic Shock, Respiratory Failure and Pneumonia, *Coding Clinic*, Second Quarter 2005 Pages: 19 – 20.

NEXT STEPS

Please share this advisory with your hospital leadership, RAC team and all clinical, coding and billing staff involved with medical record documentation and coding. We suggest you revisit and implement those documentation and coding strategies that your organization is not already using to prepare for the national RAC program. Watch for additional member education calls and advisories from the AHA in the coming months as the national RAC program is implemented.