

# PHYSICIAN ADVISORY SERVICES

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## CMS UPDATES 3 DAY WINDOW BILLING REQUIREMENTS

On June 25, 2010, President Obama signed into law the "Preservation of Access to Medicare Beneficiaries and Pension Relief Act of 2010". The law attempts to clarify the services included in the 3 day payment window bundling requirements. All diagnostic and non-diagnostic services related to an admission rendered on the day of admission or 3 days prior to the admission are to be included in the admission billing.

According to CMS the bundling of all services for which payment may be made by Medicare is required unless "the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related to such admission." Thus, the burden of proof that the service is unrelated is placed squarely on the facility.

The provision is effective for services furnished on or after June 25, 2010; however, the legislation

prohibits Medicare from reopening, adjusting, or making payments when hospitals submit new claims or adjustment claims for services provided prior to the June 25, 2010 date in order to separately bill outpatient non-diagnostic services. This is problematic because there was a "bright line" test prior to June 25, as to the definition of "related" to the inpatient admission but CMS will not allow correction of claims filing errors based on the pre-June 25 "bright line" test.

The CMS transmittal addressing the legislation states: "in the very near future, CMS expects to provide instructions to the hospital community through its contractors advising them how to bill for related therapeutic services provided during the 3- or 1- day payment window. Until the instruction is issued, hospitals should include charges for all diagnostic services and all non-diagnostic services that it believes meet the

requirements of this provision. If a hospital believes that a non-diagnostic service is truly distinct from and unrelated to the inpatient stay, the hospital may separately bill for the service provided that it has documentation to support that the service is unrelated to the admission, consistent with the new provision. Such separately billed service may be subject to subsequent review."

Without guidance as to whether a service is "related" to the admission, hospitals must be prepared to document that billed non-diagnostic services are "unrelated" clinically to the admission. This additional requirement of clinical analysis and documentation must be incorporated into the billing process. Without a bright line test, clinical staff will have to be involved in the billing process to bill for "unrelated services" provided in the 3 day window. We will keep you posted regarding updates.



## RAC FAQs - EXCERPTS FROM CMS WEBSITE

***"I received an additional documentation request (ADR) letter from a Recovery Audit Contractor (RAC) for an issue that is not approved on their website. Do I need to submit the record?"***

RACs may request a small sample of records to assist

CMS in determining if an audit concept is consistent with Medicare policy and should be approved for wide-spread review. Providers must still submit the requested documentation to the RAC within the expected timeframe to avoid having

that claim denied. The RAC will complete its review of the claim and issue a review results letter within 60 days."

*(In June 2010, many RAC FAQs were updated on the CMS Website. To review a complete list of the RAC FAQs click here.)*

Click this link to be directed to The Medicare RAC Program: Update to the Evaluation of the 3 Year Demonstration, June 2010:  
<http://www.cms.gov/RAC/Downloads/DemoAppealsUpdate61410.pdf>

### THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM: UPDATE TO THE EVALUATION OF THE 3 YEAR DEMONSTRATION PROGRAM

In June CMS published an update of the RAC Demonstration Program Evaluation report which was released in July 2008. The July 2008 report included information through March 27, 2008. The June 2010 report provides updated appeals statistics through March 9, 2010 for RAC claims. The table below shows the updated appeals information by the individual RAC. The informa-

tion shows that for all RACs 12.7% of the overpayment claims were appealed. Of the 12.7% of the claims, 64.4% were overturned in favor of the provider. 8.2% of all claims were overturned on appeal. Connolly had the lowest number of claims appealed at 7.0% with 66.9% of those claims being overturned.

mined to be overpayments by the RACs and appeal those in order to reduce the recoupments. The results show that there is a high probability that through the appeal process the claims will be overturned in favor of the provider.

Providers should be ready to review the claims deter-

For assistance on how to plan an appeals strategy, call Ann Purdy at 205-314-8859 or email her at: [apurdy@medmanagementllc.com](mailto:apurdy@medmanagementllc.com).

#### PROVIDER APPEALS OF RAC-INITIATED OVERPAYMENTS: CUMULATIVE THROUGH 8/31/08, RAC CLAIMS, ALL CLAIM TYPES (APPENDIX 1A OF THE REPORT)

Claim RAC	Claims with Overpayment Determinations	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	118,152	8,286	7.0%	5,543	66.9%	4.7%
HDI	309,080	44,778	14.5%	32,628	72.9%	10.6%
PRG	171,006	14,965	8.8%	7,448	49.8%	4.4%
RAC not known1	n/a	8,044	n/a	3,374	41.9%	n/a
All RACs	598,238	76,073	12.7%	48,993	64.4%	8.2%

#### Region A-DCS

<http://www.dcsrac.com/issues.html>

#### Region B-CGI

<http://racb.cgi.com/Issues.aspx?st=1>

#### Region C-Connolly Healthcare

[http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)

#### Region D-HCI

<https://racinfo.healthdatainsights.com/Public/NewIssues.aspx>

### RACS POST NEW ISSUES IN JUNE

Three of the four RACs posted new issues in June. Region A posted the most new issues including 39 DRG validation issues. Region C RAC, Connolly added one issue for

Automated Review which was dose vs. units billed for Zoledronic acid. Two DRG Validations (MS-DRG 840 and MS-DRG 247) were also added. Although issues including

reviews for Medical Necessity have been approved by CMS none of the RACs have posted the issues as approved on their websites.