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RAC complex review: Target audit issues

By Jillian Bower

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Although the Centers for Medicare and Medicaid Services (CMS) implemented the Recovery Audit Contractor (RAC) as a permanent program over a year ago and has expanded it to all 50 states, few providers have undergone RAC audits so far. Therefore, compliance officers can take advantage of the slower-than-expected rollout to ensure that their organization is ready for a RAC audit. The RAC program is now in full force. In the early stages, the RACs focused exclusively on automated reviews and most providers have become aware of this process. However, now is the time to become familiarized with the complex reviews, especially the approved audit issues. Complex reviews involve the use of clinical judgment by a licensed medical professional or certified coding specialist to evaluate medical records. Complex reviews are initiated by the RACs when they identify a significant probability that the service is not covered or when no Medicare policy, article, or coding guidelines exist. The purpose of coding and diagnosis-related group (DRG) validations is to determine that the principal diagnosis and all secondary diagnoses identified in the medical record are actually present and correctly sequenced and coded.

Complex reviews

In order to conduct a complex review, RACs will request medical records from the selected providers and then manually review the documents to determine the validity of the claims and corresponding reimbursements. CMS implemented a new record request limit for fiscal year 2010. The number of records the RACs may request is calculated based on the provider's Tax Identification Number (TIN) and the number of claims submitted during calendar year 2008. Specifically, the request limit will be set at 1% of all Medicare claims submitted in the previous year divided by eight reporting periods (i.e., 45 days). However, a cap of 300 records requested every 45 days applies to providers who bill more than 100,000 Medicare claims.

The approved audit issues include specific MS-DRG codes related to a medical procedure. In auditing these MS-DRG codes, RACs will focus on providers' compliance with coding rules. Specifically, the DRG validation complex reviews involve an in-depth evaluation of the patient's medical record in order to determine that the diagnosis and procedures used to establish the Medicare severity (MS) DRG for the claim is correct. Because the MS-DRG code determines the reimbursement amount for the service, it is essential that the correct code is submitted in order to receive the correct reimbursement for the service.

Audit issues

RACs are using complex reviews to target certain DRGs and coding errors. Prior to conducting complex reviews, the RACs must receive approval from CMS on specific audit issues. Currently, on their websites, all four RACs report approved issues for complex and DRG validation reviews. The number of issues approved for review, and even which issues are approved for review, varies among the RACs. Diversified Collection Services (Region A) has six approved issues, mostly related to inpatient respiratory procedures. Conversely, CGI Federal (Region B) has 58 approved issues related to numerous inpatient and outpatient medical procedures, including respiratory, cardiac, gastroenteritis, kidney, urinary, liver, and operating room procedures. Similarly, Connolly Healthcare (Region C) has over 100 audit issues approved for various inpatient procedures, including respiratory, cardiac, joint and bone, cranial, burn and debridement, organ transplant, gastrointestinal, circulatory system, and operating room procedures. Lastly, Health Data Insights (Region D) received approval on 49 DRG validation issues also inclusive of various inpatient procedures, such as infection, nervous system, cardiovascular, eye, septicemia, operating room, respiratory, and gastrointestinal procedures. Since late 2009, the RACs have received approval from CMS on these various audit issues. As a result, RACs have begun complex reviews and providers can expect more in the coming year.

It is important for providers to stay aware of the audit issues posted by their RACs, especially items and services where the RACs have a particular focus. A specific audit area that has raised much attention regards incorrect coding for sepsis or septicemia. In many cases, upon review of the medical records, the RAC auditor determines that the diagnosis rendered is urosepsis. Symptoms of sepsis may be present and noted, however, the medical record does not fully support a diagnosis of sepsis. Further review of these medical records reveals that, in some cases, the blood cultures were negative and additional documentation does not meet the coding guidelines for septicemia.

Another instance where RAC auditors have determined that sepsis was wrongly coded is present on admission (POA). After review of

the medical records, the RACs determined that the record does not well document whether sepsis was present when the patient was admitted.

Table 1 is a summarized list of audit issues approved for complex reviews.

Table 1

Amputation DRG Codes:

239	240	241	255	256	257
474	475	476	616	617	618

Burn DRG Codes:

927	928	929	933	934	935

Cardiac Procedure DRG Codes:

034	035	036	215	222	223
224	226	227	231	232	233
234	235	236	242	243	244
245	246	247	248	249	258
259	260	261	262	265	286
287					

Eyes, Nose, Mouth & Throat Procedure DRG Codes:

113	114	115	116	117	129
130	131	132	133	134	135
136	137	138	139		

Gastrointestinal Procedure DRG Codes:

326	327	328	329	330	331
332	333	334	335	336	337
338	339	340	341	342	343
344	345	346	347	348	349
350	351	352	353	354	355
356	357	358	405	406	407
408	409	410	411	412	413
414	415	417	418	419	420
421	422	423	424	425	

Infection DRG Codes:

094	095	096	853	854	855
867	868	869			

Kidney & Urinary Tract Procedure DRG Codes:

652	653	654	655	656	657
658	659	660	661	662	663
664	665	666	667	668	669
670	671	672	673	674	675
691	692	693	694		

Nervous System Procedure DRG Codes:

020	021	022	023	024	025
026	027	028	029	030	031
032	033	037	038	039	040
041	042				

OR Procedure Unrelated to Principal Diagnosis DRG Codes:

981	982	983	984	985	986
987	988	989			

Septicemia DRG Codes:

870	871	872			

Transplants DRG Codes:

001	002	003	004	005	006
007	008	009	010	011	012
013					

Although correct coding is essential, proper sequencing of the codes is just as important, because it affects MS-DRG assignment and payment. Sequencing is something coders struggle with, because the circumstances of admissions are often somewhat debatable, leading to questions of the principal diagnosis. On admission, the provider assigns a particular DRG based on a combination of the principal diagnosis, accompanying additional diagnosis such as complications or comorbidities (CC) or major complications or comorbidities (MCC), and the principal procedure. For that reason, if the provider initially reports an incorrect code as the principal diagnosis, the assigned DRG may also be incorrect. According to the ICD-9-CM Guidelines for Coding and Reporting, when two interrelated conditions both meet the criteria of a principle diagnosis, coders are allowed to sequence either one of the diagnoses first. On the other hand, both diagnoses potentially may appear to meet the definition, but in fact, neither one does.

Even though CMS is moving forward with the permanent RAC program, they have not forgotten the success of the RAC demonstration program. This is evident in the audit issues CMS is approving for the permanent program. Connolly Healthcare (Region C) and Health Data Insights (Region D) were both contractors during the demonstration program. Audit issues that lead to the identification of high overpayments and underpayments are issues these contractors are using during the permanent program. For example, DRG codes determined to be incorrectly coded due to wrong diagnosis code or principal assignment or due to wrong procedure code accounted for 26% of overpayments identified. Additionally, audits of inpatient hospitals found two of the highest yielding audits were for incorrectly coded excisional debridement and respiratory system diagnosis—both are areas the RACs are currently auditing.

Additionally, the RACs are also currently auditing items and services that resulted in high amounts of underpayments during the demonstration program. These items and services include wound debridement, operating room procedures unrelated to the principle diagnosis, respiratory system procedures, surgical procedures with an incorrect DRG, circulatory system diagnosis, bowel procedures, respiratory infections, kidney and urinary infections, and pneumonia.

Best practices

By now, providers should know who their RAC auditor is. The RACs are required to

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post approved audit issues on their websites. Compliance professionals should visit the RAC's website to review the approved audit issues and to find an updated list of targeted MS-DRGs. Knowing which MS-DRG codes your RAC will review allows you to conduct an internal audit to verify compliance with billing and coding rules and to establish a process to remediate any identified errors.

After conducting an internal audit, providers should identify their top coding errors. These may or may not be the same MS-DRG codes the RAC is also targeting. Providers should establish procedures to remediate and prevent further coding errors for these particular MS-DRGs. For example, claims containing specific MS-DRG codes should be sent to a lead coder for a prepayment review to ensure that the correct procedure code assignment, sequencing of principal diagnosis, and CC or MCC code assignment was used.

Next, education should be provided regarding vulnerabilities related to the specific MS-DRG codes. Both physicians and coders can contribute to coding errors; therefore, providers must make it essential that all those involved are educated and knowledgeable about the possible errors. For example, the Compliance department, in collaboration with the Billing and Coding department, can develop a one-page education document which highlights the procedures that have high coding errors and how to properly document medical records involving these issues.

Then, implement a monitoring process to continually review top coding errors, which may involve pre- and post-payment review of claims. It is equally important to monitor and review the errors reported by the RAC in the demand letter. The results determined by the RACs and other contractors and government agencies are based upon statistical overpayment extrapolations. Providers should not assume that the statistical approaches used by these contractors are always valid. Providers have a right to review the methodology, estimates, and the confidence level of the projected errors. If the method is flawed, it provides immediate grounds for appeal.

The key to successful coding is to get the MS-DRG code correct in the beginning. Therefore, it is essential that the clinical documentation matches the service billed and the physician's documentation must be precise when a patient is admitted. Moving forward, billing and coding compliance and internal audits must become a routine part of your facility. ■

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