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Lessons from RACs Improvements to ensure maximum payments

The RACs are having a significant financial impact on hospitals. But hospitals are taking steps to improve the accuracy of their claims and, therefore, payment.

AT A GLANCE

The RACs have taught some expensive lessons to providers. As a result, hospitals are taking a closer look at their billing and clinical documentation practices. Improvements include physician education and automation of the revenue cycle.

The Centers for Medicare & Medicaid Services (CMS) recovery audit contractors (RAC) program looms large over healthcare facilities, and with good reason: Of the nearly \$1 billion in overpayments recovered from healthcare providers and suppliers during the three-year RAC demonstration program, a staggering 85 percent came from inpatient facilities.

In its evaluation of the program, released in June 2008, CMS reports that RACs successfully corrected more than \$1.03 billion in improper Medicare payments. And although the program is designed to identify and correct both overpayments and underpayments, 96 percent (\$992.7 million) comprised overpayments collected from providers; just 4 percent (\$37.8 million) was repaid to providers to correct Medicare underpayments.^a

The most common cause of overpayments to inpatient facilities was the submission of claims that did not comply with Medicare's coding or medical necessity policies. Of the 14 percent of RAC determinations that were appealed, just 4.6 percent of the appeals were successful.

In all, CMS estimates that it will recover approximately \$3 billion in overpayments through the RAC program.

Lack of System Confidence

For CFOs in particular, the RAC program poses a significant dilemma. Charged with generating appropriate revenue levels, CFOs have to ensure that their facilities are aggressively pursuing the highest billing levels possible. Doing so can be risky, however. Failure to properly capture data at any point

a. Centers for Medicare & Medicaid Services, *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, June 2008 (www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf).

along the clinical documentation and coding continuum will result in a lack of proper documentation to justify higher billings. That is exactly what RACs are looking for.

Without appropriate systems in place to fully and accurately capture the data necessary to support payment claims, the likelihood of receiving a demand for repayment is extremely high—and the likelihood of winning on appeal is extremely low. For hospitals already operating on razor-thin margins, even a relatively small repayment can be a devastating blow to the bottom line.

It is a very real concern. A survey of 175 health information management (HIM) directors nationwide conducted on behalf of Wolters Kluwer Health found that 88 percent anticipate a negative financial impact due to overpayments or that the facility will, at best, come out even. The independent survey, released in August 2008, provides insight into the reasons behind these grim expectations. Simply put, there is little confidence in the accuracy or completeness of the data being captured by procedure documentation and coding systems:

- > In the case of overpayment as a result of incorrect coding, 42 percent of respondents said that either the claim code or the medical record is likely to be incorrect and 34 percent said an incorrect claim code is the most likely cause of the error.
- > Forty-eight percent were at least moderately concerned about mismatched facility and professional claims.
- > Twenty-nine percent felt that their facility captures co-morbidity codes for Medicare severity diagnosis-related group (MS-DRG) billing codes only “somewhat effectively” and 2 percent said codes were captured “not very effectively” or “not at all effectively.”

Mitigating the financial impact of the RAC program is difficult because the damage is already done. However, the majority of HIM directors surveyed (81 percent) said their facilities were taking action to improve the accuracy of future Medicare claims. Of those, the majority (77 percent)

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conducted internal audits, implemented a document improvement program (66 percent), and/or created a special task force to examine documentation, coding, and billing (57 percent). Others installed new software to capture correct documentation, coding, and billing (33 percent) and/or hired additional coders (18 percent).

A Broken System

Although efforts under way to improve claims accuracy are laudable, most are little more than stop-gap measures. They will have a positive impact, but they will not result in systemwide improvements that will allow CFOs to obtain full payment for services rendered.

The spotlight that the RAC program has turned on the weaknesses with internal systems and processes is one of the positives to have emerged from the program. Specifically, issues with procedure documentation at the front end impact the ability to code at appropriate levels on the back end. This often means a loss of revenues due to overly conservative billing practices, or delays in the revenue cycle when gaps in documentation must be filled to complete the process or to respond to payers' requests for justification.

The problem is that most systems are manual and largely paper-based. They depend upon physicians to properly dictate and document the services provided and on coders to apply the proper corresponding Current Procedural Terminology (CPT[®]) and ICD-9 codes and Correct Coding Initiative (CCI[®]) edits, optimize them against DRGs, and deliver them for billing at the highest appropriate level.

Each step carries a risk that will affect the level and accuracy of the bill that is generated, so it is

understandable that greater scrutiny by the RAC program has raised CFOs' anxiety levels. They have no way to know just how high the risk for error is, or whether their internal systems will withstand heightened scrutiny. Any errors or omissions will force the return of revenues, and could have a personal impact if the overpayment is deemed to be the result of fraud rather than a simple mistake.

Their anxiety is well deserved. For example, the 2008 study found that, among participating hospitals that captured co-morbidity codes for MS-DRG billing codes for patients admitted via the cardiac catheterization lab, 59 percent found effective capture of this information to be at least "somewhat challenging."

"Challenging" may be an understatement, particularly for complex service lines such as cardiology and gastroenterology. One facility's internal audit found error rates as high as 90 percent in their cath lab, and another found an average error rate of 70 percent in cardiology peripherals.

Fixing What's Broken

Hospitals can implement several strategies to fix what is broken in the clinical documentation and coding system. One strategy that has shown promise is deployment of concurrent coding programs.

A study published in the September 2007 issue of the *Journal of Clinical Outcomes Management* found that concurrent coding increased severity of illness by 16 percent and risk of mortality by 17 percent. It also increased severity of illness by one category in 27 percent of patients and the risk of mortality by one category in 23 percent of patients, changes that can significantly affect payment.^b

Another strategy is educating physicians on correct and compliant documentation. Here, a particular focus is often on the documentation of

secondary diagnoses, which can have a significant impact on payment levels. When ongoing training based on service line is provided, the quality and completeness of physician documentation improves, resulting in faster and more accurate coding and higher billings.

However, these strategies merely plug individual holes in the system. They may result in some process improvements, but they cannot eliminate the human errors that are most often to blame for the overcoding or undercoding that results in improper payments. These coding errors include incorrect coding, which was blamed for 35 percent (\$331.8 million) of overpayments recovered by CMS during the RAC demonstration program, and no or insufficient documentation, which was blamed for 8 percent (\$74.3 million) of overpayments.

Consider the cardiology documentation process. During catheterization procedures, physiological monitoring systems gather an abundance of information such as hemodynamic data, medications, supplies used, and other specific measurements. This information is often compiled in a data worksheet that the physician or technologist reviews and dictates for inclusion in the procedure record.

Dictation often must be done in a separate phone or dictation room and may not happen for days or even weeks. To keep up with busy procedure schedules, physicians may rush through dictation once they do find the time to do it.

Once it is in their hands, coders can only work with the information provided in the clinical documentation. In some cases, they may spot potential gaps and follow up to get the necessary information to code at the most appropriate levels. When that information is not provided or when the gaps are not identified and filled, undercoding is the most likely outcome and money is left on the table.

The entire process is redundant and inefficient, and the added manual steps increase the possibility for documentation error.

b. Stonemetz, J., Pham, J.C., Marino, R.J., Ulatowski, J.A., and Pronovost, P.J., "Effect of Concurrent Computerized Documentation of Comorbid Conditions on the Risk of Mortality Index," *Journal of Clinical Outcomes Management*, September 2007, pp. 499-503.

Exacerbating the problem, separate teams of coders review documentation and assign coding that is used to generate separate bills for professional and facility fees. Rarely do these coding teams work in conjunction, with bills sent separately to third-party payers without internal reconciliation.

Ambiguous or incomplete documentation is often interpreted and therefore coded differently by these two teams. If the physician bills for services that vary from those submitted by the facility, a red flag is raised with payers. According to the Office of Inspector General (OIG), 23 percent of all claims do not match between the facility and the professional components.

At best, rejected bills will require costly handling before resubmission. At worst, they can lead to permanent loss of revenue. And if the RAC program is not enough of a threat, the OIG, acting through the National Health Care Fraud and Abuse Control Program (HCFAC), is now checking for discrepancies between professional and facility fees and has already levied recent record-breaking fines in the millions for construed overbilling.

Automating Out Human Error

The only real way to eliminate the redundancies, inefficiencies, and human errors that plague most clinical documentation and coding systems is automation. It can eliminate 98 percent of the risk of lost revenues due to paybacks and speed the revenue cycle by eliminating the delays caused by missing or incomplete documentation.

It can also reduce costs associated with transcription, image printing, and storage; eliminate dictation and transcription delays; streamline workflows; and increase patient throughput—all of which will have a direct and positive impact on the bottom line.

Although a number of service line-specific automation solutions are available, most fail to close key gaps in the process. For example, cardiovascular information systems (CVIS) do an

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excellent job of delivering such key functionality as digital image management, archiving, reporting, and workflow management, and can typically integrate the records, picture archiving and communication system, and modalities from cardiac operating rooms, echo labs, and cath labs with other hospital departments. However, they do not address the issue of automating physician documentation at the point of care—something 90 percent of respondents to a KLAS CVIS perception study identified as essential. Nor do they automate the coding process, a tie to billing/patient accounts considered essential by 40 percent of the KLAS respondents.^c

A new breed of procedure documentation and coding systems is closing these gaps by expanding functionality to include medical content-driven menus that emulate typical procedure workflow and follow logical paths that automatically adapt to each piece of information that the physician selects. As a physician completes documentation and incorporates and labels images, the software maps clinical content directly to billing codes, automatically generating correct CPT and ICD-9 codes as well as CCI edits, including all appropriate modifiers.

The benefits of such a system are realized almost immediately, as New Mexico Orthopaedics

c. KLAS, CVIS Perception Study, December 2007.

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discovered when it replaced physician procedure dictation with an automated documentation and coding solution. Designed by an in-house team of physicians and coders, the software selected by New Mexico Orthopaedics allows physicians to create and e-sign clinical notes immediately after a procedure, replacing dictation and transcription. Menu selections made by physicians create detailed clinical notes complete with diagrams that read just as if they were dictated. Based on that medical content, appropriate billing codes are applied and are ready for review by HIM and coding staff. The result is coder-ready documentation delivering compliance, proper payment, and shortened days in accounts receivable.

Eliminating documentation and coding errors is a primary benefit of automating the procedure documentation process. But it is not the only one.

Opened in February 2000 as a joint venture between physicians and United Surgical Partners International, New Mexico Orthopaedics features six operating rooms and a physician practice that includes 16 orthopedic surgeons and three physiatrists, as well as nonpartner physicians who perform surgeries at the site.

Like many ambulatory surgery centers and hospitals, coding at New Mexico Orthopaedics tended to err on the conservative side. Although that was the best way to avoid audits and fines that come from accidental overbilling, it was a drain on revenues. A predeployment audit showed significant undercoding, and therefore underbilling that, when applied to an annual average caseload of 4,300 procedures, totaled \$596,000 in lost revenues. That total included \$282,600 in professional underbilling and \$313,000 in facility underbilling.

To determine the financial impact of automating the procedure documentation process, a

postimplementation audit was undertaken that consisted of initial client interviews; data gathering of pre- and postprocedure reports and billing codes; on-site interviews and workflow analysis; and off-site data analysis to independently review and confirm results. The audit showed that, as a result of automation, New Mexico Orthopaedics realized a 117 percent overall improvement in documentation and coding accuracy. Professional documentation and coding errors decreased by 53 percent, while facility errors decreased by 42 percent. There was also a 12 percent decrease in mismatches between facility and professional codes.

Eliminating documentation and coding errors is a primary benefit of automating the procedure documentation process. But it is not the only one. For example, although overall procedure volume remained roughly the same postautomation, San Francisco General Hospital realized an annual increase in gastroenterology fee billings of 22 percent and an average increase of 33 percent for the amount billed per procedure. Actual payment for gastroenterology services also rose by approximately 50 percent.

Two integrated healthcare delivery organizations that were the focus of a First Consulting Group (FCG) study conducted on behalf of ProVation Medical realized a 50 percent improvement in the coding accuracy of professional and facility claims after deployment of a multispecialty documentation and coding compliance solution. FCG projected that this improved coding would be associated with increased payment of 15 percent or more for the departments in which the tool is used, improving the organizations' overall profitability by 1 percent to 2 percent. In addition, because more specific codes were generated by the application, FCG predicted that the participating organizations were also likely to achieve additional cost savings from improved coding compliance.

Rapid ROI

The idea of deploying yet another information system is sure to elicit groans from CFOs who are

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already struggling to find ways to fund and maintain existing IT investments. However, the right clinical documentation and coding system will pay for itself far more quickly than most.

Between the cost savings generated by eliminating transcription and other fees and the revenue gains realized by capturing all the charges to which a hospital is entitled, the typical payback for a cardiac documentation and coding system is 12 months to 18 months. These systems also ensure that the appropriate supporting documentation is always ready to successfully support appeals when an overpayment determination is made.

By automating the clinical documentation and coding system with a solution that is physician-friendly to ensure rapid and widespread adoption, hospitals can streamline the overall process

and remove the weaknesses inherent in a manual system. The end result is the ability to aggressively pursue maximum payments for services rendered without fearing the wrath of RAC. ●

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