Pyramid Healthcare Solutions

WORLD OF AUDITS/DENIALS

Patient Financial Services

Coding & Auditing Services

HIM & Cancer Registry Services

Pharma Regulatory Compliance

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TYPES OF AUDITS & DENIALS

- MEDICALLY NECESSARY
- MEDICALLY UNLIKELY EDIT (MUE)
- NO AUTHORIZATION
- PARTIAL AUTHORIZATION
- CODING AND DOCUMENTATION
- PROCEDURE PRE-AUTHORIZED – DIFFERENT PROCEDURE BILLED
- PROCEDURE DENIED-NO LONGER VALID
- RAC (RECOVERY ACT CONTRACTOR)

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- **CMS DEFINITION:**

  MEDICALLY NECESSARY SERVICES OR SUPPLIES THAT ARE: PROPER AND NEEDED FOR THE DIAGNOSIS OR TREATMENT OF YOUR MEDICAL CONDITION, ARE PROVIDED FOR THE DIAGNOSIS, DIRECT CARE, AND TREATMENT OF YOUR MEDICAL CONDITION, MEET THE STANDARDS OF GOOD MEDICAL PRACTICE IN THE LOCAL AREA, AND ARE NOT MAINLY FOR THE CONVENIENCE OF YOU OR YOUR DOCTOR.

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1. LAB OR RADIOLOGY TESTING- DIAGNOSIS DOES NOT SUPPORT TESTS
2. PATIENT COULD HAVE BEEN TREATED AT LOWER LEVEL OF CARE
3. PER INSURANCE CONTRACT/POLICY MUST MEET SPECIFIC CRITERIA TO BE CONSIDERED MEDICALLY NECESSARY
4. OBSERVATION VERSUS INPATIENT

- MEDICARE LEARNING NETWORK (MLN MATTERS NUMBER SE 1037)
  - MEDICAL NECESSITY FOR INPATIENT:
    - A. ADMISSION CRITERIA
    - B. INVASIVE PROCEDURE CRITERIA
    - C. CMS COVERAGE GUIDELINES
    - D. PUBLISHED CMS CRITERIA
    - E. OTHER SCREENS, CRITERIA & GUIDELINES

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- THE BENEFICIARY MUST DEMONSTRATE SIGNS AND SYMPTOMS SEVERE ENOUGH TO WARRANT THE NEED FOR MEDICAL CARE AND MUST RECEIVE SERVICES OF SUCH INTENSITY THAT THEY CAN BE FURNISHED SAFELY AND EFFECTIVELY ONLY ON AN INPATIENT BASIS
  - Medicare Benefit Policy Manual, Chapter 1, Section 10
  - http://www.cms.gov/Regulations -and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf

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- THE CMS DEVELOPED MEDICALLY UNLIKELY EDITS (MUEs) TO REDUCE THE PAID CLAIMS ERROR RATE FOR PART B CLAIMS. AN MUE FOR A HCPCS/CPT CODE IS THE MAXIMUM UNITS OF SERVICE THAT A PROVIDER WOULD REPORT UNDER MOST CIRCUMSTANCES FOR A SINGLE BENEFICIARY ON A SINGLE DATE OF SERVICE. ALL HCPCS/CPT CODES DO NOT HAVE AN MUE.

- AN MUE FOR A HCPCS/CPT CODE IS THE MAXIMUM NUMBER OF UNITS OF SERVICE (UOS) UNDER MOST CIRCUMSTANCES REPORTABLE BY THE SAME PROVIDER FOR THE SAME BENEFICIARY ON THE SAME DATE OF SERVICE. THE IDEAL MUE VALUE FOR A HCPCS/CPT CODE IS ONE THAT ALLOWS THE VAST MAJORITY OF APPROPRIATELY CODED CLAIMS TO PASS THE MUE. NCCI Policy Manual for Medicare Services - Effective January 1, 2014

- MAJORITY OF EXISTING MUEs POSTED ON THE CMS WEBSITE ACCESSED THROUGH THE MUE WEBPAGE: http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

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- **Patient Registration Issues**
  1. INSURANCE OFFICE CLOSED
  2. WEBSITE NOT FUNCTIONING
  3. INCORRECT PLAN/ID
  4. INCORRECT INSURANCE GIVEN BY PATIENT
  5. NO INSURANCE INFORMATION AVAILABLE
  6. NO VERIFICATION OF ELIGIBILITY/BENEFITS
  7. NO PRE-AUTHORIZATION
  8. STAFF ATTEMPTED-INSURANCE REQUESTED MEDICAL REVIEW-FACE SHEET–NEVER RESPONDED WITH AUTHORIZATION NUMBER

- TIMELY FILING- EXTENUATING CIRCUMSTANCES
- PRIMARY CARE PHYSICIAN DID NOT OBTAIN –NO PRE-AUTHORIZATION
- PROCEDURE AUTHORIZED- DRUG USED FOR THE PROCEDURE DENIED
- SERIES OF TREATMENTS: NUMBER OF VISITS AUTHORIZED USED-NEED TO EXTEND EXISTING AUTH. NUMBER OR ASK FOR NEW AUTH. NUMBER TO COVER REMAINING DAYS
- AUTHORIZATION FOR SPECIFIC CODE BUT BILLED A DIFFERENT CODE
- NEWBORN NOT ON POLICY

- **PSYCHIATRIC CLAIMS**

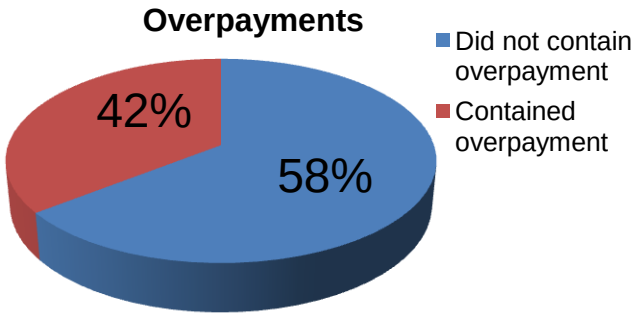
  APPROVED FOR A NUMBER OF DAYS AND THEN MUST HAVE A MEDICAL REVIEW FOR ADDITIONAL DAYS
- **ER:** PATIENT - BAKER ACT- MEDICALLY CLEARED AND ADMITTED AS INPATIENT IN PSYCH UNIT
  1. INSURANCE CONTRACT – IF PATIENT ADMITTED ON SAME DAY AS ER VISIT WILL PAY FOR ER CHARGES
  2. INSURANCE CONTRACT – WILL NOT PAY FOR ER VISIT. MUST BILL THE ER CHARGES TO THE PATIENT'S MEDICAL INSURANCE COVERAGE

- **UM ISSUES**
  - INSUFFICIENT AUTHORIZATION:
    - LENGTH OF STAY
    - LEVEL OF CARE
    - SERVICE

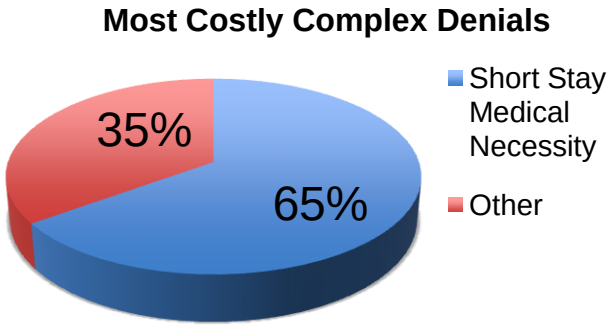
- **INITIAL CLAIMS FOLLOW-UP ISSUES**
  - INSUFFICIENT BILL EDITS:
    - DATE OF ACCIDENT
    - DATE OF MEDICAL EMERGENCY
    - DATE OF ONSET
- **CLAIMS SUBMISSION ISSUES**
  - REQUESTED (REASONABLY NECESSARY) DOCUMENTS NOT SUBMITTED
  - INSUFFICIENT BILL EDITS
  - CLAIM SENT TO WRONG ADDRESS/UNIT
  - CLAIM NOT SUBMITTED TIMELY
  - CODING TO HIGHEST LEVEL OF SPECIFICITY
  - CHARGE MASTER: UPDATED WITH CURRENT CPT CODES
  - DIAGNOSIS CODES: UPDATED WITH CHANGES/DELETIONS AND HIGHEST LEVEL OF SPECIFICITY

RECOVERY AUDIT CONTRACTORS

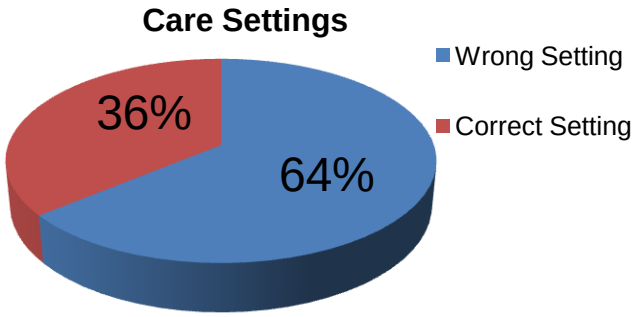
- UNITED STATES CONGRESS DIRECTED THE DHHS TO CONDUCT A PROGRAM TO DETECT AND CORRECT IMPROPER PAYMENTS FOR THE MEDICARE FFS 58% OF MEDICAL RECORDS REVIEWED BY RAC DID NOT CONTAIN AN OVERPAYMENT, ACCORDING TO RAC



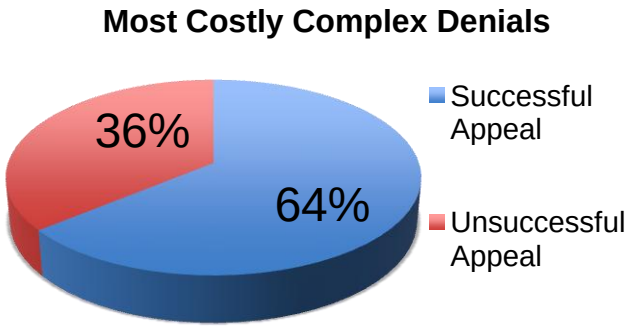
- 65% OF HOSPITALS INDICATED SHORT-STAY MEDICAL NECESSITY DENIALS WERE THE MOST COSTLY COMPLEX DENIALS



- 64% OF SHORT-STAY DENIALS FOR MEDICAL NECESSITY WERE DUE TO THE CARE BEING PROVIDED IN THE WRONG SETTING, NOT BECAUSE IT WAS NOT MEDICALLY NECESSARY

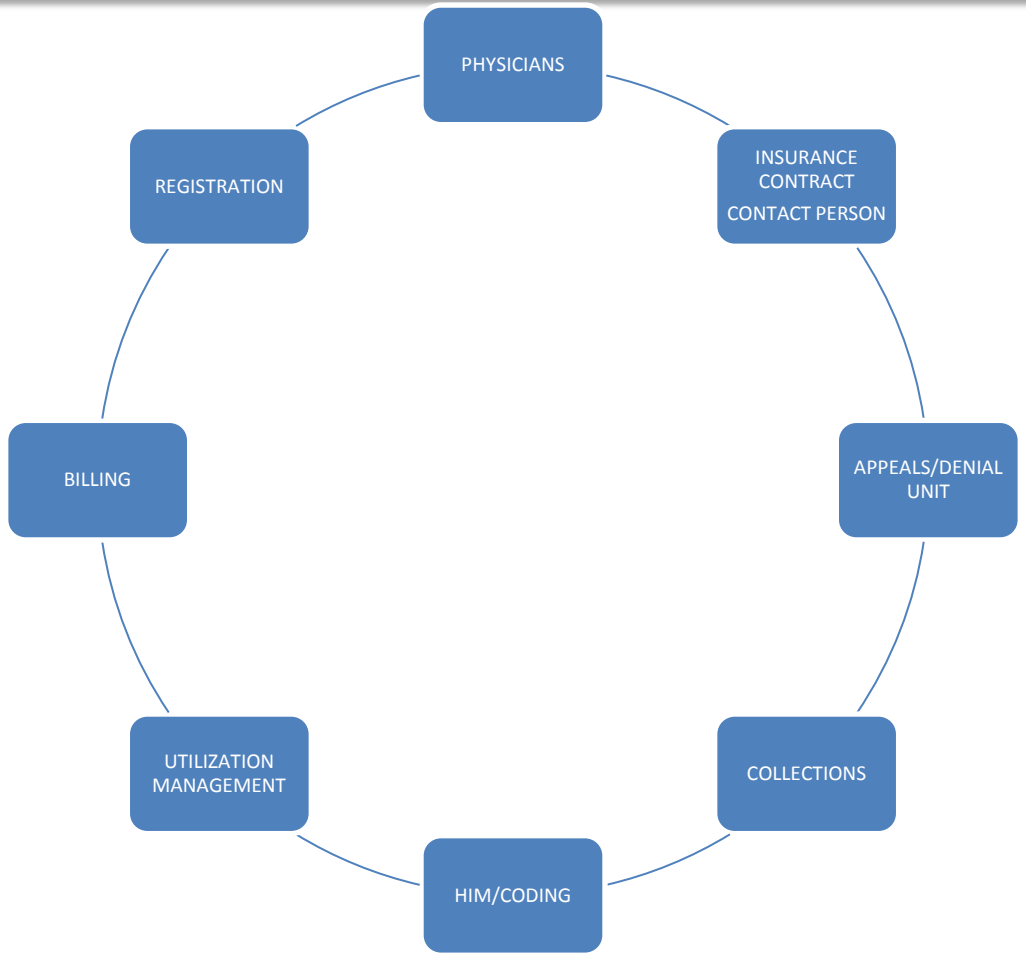


- HOSPITALS REPORTED APPEALING 49% OF ALL RAC DENIALS, WITH A 64% SUCCESS RATE IN THE APPEALS PROCESS



- **DENIALS/APPEALS**:
  - SPECIFIC PAYORS
    - EXAMPLE: WEBSITE FOR PAYOR NOT AVAILABLE FOR ELIGIBILITY OR AUTHORIZATIONS ON WEEKENDS
  - SPECIFIC CPT CODES OR DIAGNOSIS CODES
    - EXAMPLE: DIAGNOSIS NOT TO HIGHEST LEVEL OF SPECIFICITY-CODED INCORRECTLY-NOT THE PRIMARY DIAGNOSIS
    - EXAMPLE: CPT CODE CODED INCORRECTLY
  - SPECIFIC TO DEPARTMENT
    - I.E. REGISTRATION: CHOOSING WRONG INSURANCE CO.

REVENUE CYCLE TEAM MEMBERS



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TEAM COLLABORATION

- A TEAM EFFORT IS REQUIRED TO PREVENT OR SIGNIFICANTLY REDUCE DENIALS/APPEALS
- PHYSICIANS- REFERRING AND EMPLOYEES
- PATIENT ACCESS-REGISTRATION
- BILLING UNIT
- UTILIZATION MANAGEMENT
- HIM/CODING
- COLLECTIONS
- INSURANCE CONTRACTS-CONTACT PERSON

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ACTION PLAN

- COMMUNICATE WITH ALL DEPARTMENTS
- STRESS THE IMPORTANCE OF ATTENTION TO DETAIL
- IDENTIFY-TRENDS/ISSUES
- STRESS THE IMPORTANCE OF DOCUMENTATION-FOR ALL INVOLVED I.E REGISTRATION NOT ABLE TO USE WEBSITE ETC.
- IDENTIFY DENIALS AND WORK IMMEDIATELY
- UTILIZATION MANAGEMENT-REVIEW FOR IP CRITERIA-LENGTH OF STAY

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ACTION PLAN CON'T

- KNOW CONTRACTS-TIMELY FILING SUBMISSION; DENIAL APPEALS SUBMISSION
- IDENTIFY DEPARTMENTS CONSISTENTLY WITH LATE CHARGES
- DETERMINE ROOT CAUSE ON ALL ISSUES/TRENDS
- PARTIES INVOLVED NEED TO DETERMINE ACTION PLAN TO PREVENT REOCCURRENCE
- EDUCATE ALL STAFF OF CHANGES IN CONTRACTS; RECENT TRENDS FOUND; ROOT CAUSES AND ACTION PLANS IN EFFECT TO PREVENT FUTURE ISSUES

- AUDIT THE AUDITOR

  CONTRACT WITH OUTSOURCE AUDITING AGENCIES TO PERFORM QUARTERLY AUDITS PREVIOUSLY COMPLETED BY IN-HOUSE STAFF

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