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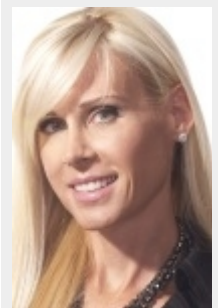
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Hospitals brace for audits of short-stay admissions

By [Jay Greene](#)



Abby Pendleton

Michigan is one of 11 states nationally targeted in a three-year demonstration project by Medicare to identify hospitals that overbill for short-stay admissions.

Millions of dollars in charges are at stake for hospitals in Southeast Michigan in the pre-payment review by private companies known as recovery audit contractors, which are hired by Medicare.

Seven of the states — Michigan, Florida, California, Texas, Illinois, Louisiana and New York — were selected for the program based on their high level of fraudulent claims, said the **Centers for Medicare and Medicaid Services**. The four other states — Pennsylvania, Ohio, North Carolina and Missouri — were selected because of high volumes for short inpatient hospital stays of about 30 hours or less.

Even if hospitals are found to have not overbilled for inappropriate short-stay admissions, the targeted hospitals could have to wait up to three extra months to get reimbursed for services rendered, said Abby Pendleton, a partner with **The Health Law Partners PC** in Southfield.

"This is a really hot issue because there is a fundamental disagreement between how reviewers are reviewing and the standards providers are given to follow" when billing, Pendleton said.

"Providers are not given black-and-white guidance."

As a way to reduce rising Medicare costs from fraud or waste, President Barack Obama ordered Medicare in 2010 to come up with a plan to reduce improper payments by \$50 billion. In 2011, Medicare saved nearly \$18 billion by reducing payment errors.

From 2006 to 2012, Medicare costs dropped from a 7 percent annual inflation rate to 2.5 percent, according to a report from **Standard & Poor's**.

Experts say the Patient Protection and Affordable Care Act, which began in 2010, has helped restrain Medicare payments to providers. In addition, the Medicare audits by recovery audit contractors, along with anti-fraud efforts, have contained costs, saving Medicare billions of dollars.

In late August, Medicare began the pre-payment review program in Michigan and the other states with a goal to recover \$2 billion in improper provider payments.

The pre-payment review program is different from Medicare's post-payment audits by recovery audit contractors, which began in 2009. Under pre-payment, Medicare scrutinizes hospital bills before they are paid but after they are presented to patients.

The post-payment audits so far have cost hospitals more than \$2.5 billion.

Over the next three years under the pre-payment review program, Pendleton said, Medicare asks Michigan hospitals to submit medical records and other supporting documents on eight diagnosis codes, along with the claims.

The eight diagnostic-related group billing codes include DRG-377, gastro-intestinal hemorrhage with major complication or co-morbidity; DRG 069, transient ischemia (minor stroke); and DRG 637, diabetes with major complication or co-morbidity.

Pendleton said Medicare is likely to add other codes to its review over the next year.

Here is how the pre-payment program review works:

- A physician determines that a patient should stay in the hospital for additional tests or to treat a short-term condition.
- Hospitals bill claims electronically, as they always do. If the recovery audit contractor flags the bill, hospitals have 30 days to provide additional documents, including medical records, to prove the appropriateness of the stay.
- The contractors have 45 days to approve or reject the claim.

"It will significantly slow up the process," Pendleton said. "I would be surprised if RAC meets the 45-day time frame."

Pendleton said one of the problems in the process comes from contractors second-guessing physician judgment.

When a patient appears in the emergency department with a complex condition, physicians sometimes are hard-pressed to make a quick diagnosis, and they sometimes opt to admit the patient temporarily to run tests.

"Did the patient collapse because of a stroke, a cardiac problem?" Pendleton said. "Afterward, some of those cases turn out not to have assertive problems, and the patient is cleared to go home after 24 hours."

At that point, she said, the Medicare contractor denies many of these claims as inappropriate admissions.

"The reviewers come in and second-guess the physician's judgment without seeing patients," Pendleton said. "They are looking at complications after the fact. Physicians have to assess patients the best they can."

The reviewers, she said, "are acting as Monday morning quarterbacks."

Because of the strictness of the review, Pendleton said, hospitals have become much more conservative in billing, losing hundreds of thousands of dollars on perfectly valid admissions.

"Hospitals are trying to carefully craft administrative policies, educate physicians and admissions staff," she said. "They may be still taking admissions, but just not billing for it."

Under the ongoing post-payment program, hospitals have challenged hundreds of thousands of dollars in claims they have submitted. Many that have appealed have been successful. While providers have appealed only about 13 percent of the overpayment decisions by recovery audit contractors, the providers have won 65 percent of the time.

"Hospitals are having great success in appealing decisions to administrative law judges," Pendleton said. "They are winning, but it takes up to a year to get paid."

To fix the recovery audit contractor program for hospitals, including pre-payment and post-payment audits, HR 6575 was introduced in August by U.S. Rep. Sam Graves, R-Mo.

The bill, supported by the **Michigan Health and Hospital Association**, would limit the number of medical record requests, require medical necessity audits to focus on areas of widespread payment errors, allow denied inpatient claims to be billed as outpatient claims when appropriate and require physician review for Medicare denial.

"Michigan hospitals have experienced ongoing frustration with the growing administrative burden of RAC audits," the association said in a statement. "Hospitals are experiencing a significant number of inappropriate payment denials amounting to hundreds of thousands of dollars in unwarranted recoupment payments for medically necessary care, and RAC operational problems are persistent and widespread."

In a recent **American Hospital Association** RACTrac survey, 55 percent of more than 2,600 hospitals spent more than \$10,000 managing the recovery audit contractor process during the second quarter of 2012, 33 percent spent more than \$25,000, and 9 percent spent over \$100,000.