

RACs Are Here – Now What?

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RAC

Recovery Audit Contractor

- Scope of work is to identify improper Medicare payments
- Collected \$1 billion in improper Medicare payments during FY 2007 in California, Florida, and New York in a three year demonstration project
- \$37 million of underpayments paid back to providers
- \$77 million to operate the demonstration program
- \$247 million was returned to the Medicare Trust Fund in 2007
- Only 7.6% of RAC reviews were overturned on appeal (as of 8/31/08)



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RAC (continued)

- 85% of these funds were collected from hospitals
- Physicians, DME, SNFs, rehab facilities, and labs were also reviewed
- RACs were paid on a contingency fee basis receiving a percentage of the improper payments they identified
- The RAC program cost only 22 cents for each dollar returned to the Trust Fund



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RAC Phase In Schedule



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References

- Reference www.cms.hhs.gov/RAC to view the CMS RAC Status Documents
- Estimates there are 3.9 percent (which is down from 9.8% percent in 2003) of Medicare dollars paid that did not comply with one or more Medicare coverage, coding, billing, or payment rules
- This equates to \$10.8 billion in Medicare overpayments and underpayments
- Too much money for Congress to ignore



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Medicare...

- Medicare receives over 1.2 billion claims per year which is approximately:
 - 4.5 million claims per work day
 - 574,000 claims per hour
 - 9,579 claims per minute



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Programs Developed

- Comprehensive Error Rate Testing Program (CERT)
 - Charged with monitoring error rates by both providers and contractors
- Error Rate Reduction Plan (ERRP)
 - Providing education, conducting pilot studies, creating new or revised national or local coverage determinations, medical necessity criteria or billing instructions



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Programs Developed (continued)

- Program Safeguard Contractors----fraud fighters
- Recovery Audit Contractors----identify improper Medicare payments
 - Does **not** detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit (Part D)
 - Starting with fee-for-service providers
 - Will include CAH's



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Revised Scope of Work for the RACs

- Look back period changed from 4 years to 3 years
- Will not be able to look back for claims paid before October 1, 2007 (before went back to 2002)
- Will be allowed to review claims in the current fiscal year (previously could not review current year claims)
- Now certified coders are mandatory for the RAC. Each RAC has 'a' Medical Director and are to 'use clinical staff when conducting medical reviews'
- There will be mandatory limits set by CMS as the number of medical records that can be reviewed for an individual facility or provider



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Revised Scope of Work for the RACs

- During the demonstration project 'discussion with the Medical Director regarding claim denials if requested by providers was optional' and now it is mandatory. Medical Director has to talk to you
- Previously there was little reporting by the RACs of problem areas they identified. Now frequent reporting is mandatory. Monthly conference calls with CMS and written reports of issues are required



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Revised Scope of Work for the RACs

- RACs have to pay back their contingency fee if the claim denial is overturned on appeal. Previously they were allowed to keep the money
- Each RAC must have a web-based application that allows providers to customize addresses and contact information or see the status of cases
- An external validation process is mandatory while previously it was optional



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Summary of Medical Record Limits (for FY 2009)

- Inpatient Hospital, IRF, SNF, Hospice
 - **10%** of average monthly Medicare claims (max of 200) per 45 days.
- Other Part A Billers (Outpatient Hospital, HH)
 - **1%** of average monthly Medicare services (max of 200) per 45 days



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Summary of Medical Record Limits (for FY 2009)

- **Physicians**
 - Solo Practitioner: **10** medical records per 45 days
 - Partnership (2-5 individuals): **20** medical records per 45 days
 - Group (6-15 individuals): **30** medical records per 45 days
 - Large Group (16+ individuals): **50** medical records per 45 days
- **Other Part B Billers**
 - **1%** of average monthly Medicare services per 45 days



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Summary of Medical Record Limits (for FY 2009)

- **Skilled Nursing Facilities**
 - **10%** of average monthly Medicare claims for 45 days
 - **200** claims/NPI



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Revised Scope of Work for the RACs

- Claims can never be reviewed by multiple contractors. If a claim has been reviewed by a program safeguard contractor or the CERT review contractor, etc., it is excluded from RAC review
- RACs cannot look for improper payments in claims where the patient is liable for an overpayment because the practitioner is without fault (the proper use of an ABN may shield claims from a RAC review—GA modifier)



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Who are the RACs?

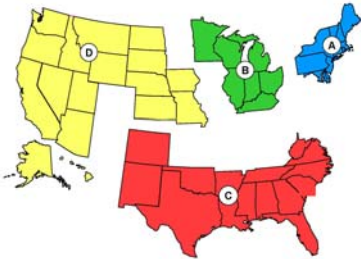
- **Selected:**
 - A. Diversified Collection Services, Inc (12.45% contingency fee)
 - B. CGI Technologies and Solutions, Inc (12.50% contingency fee)
 - C. Connolly Consulting Associates, Inc (9% contingency fee)
 - D. Health Data Insights, Inc (9.49% contingency fee)
 - Most overpayment determinations of any RAC during demonstrations project (239,205). Most overturned on appeal (11.5%)



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RAC Phase In Schedule

Proposed 2008 RAC Jurisdictions



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Who are the RACs?

- PRG Schultz will serve as a subcontractor for RACs in Regions A, B, and D.
- Vaint will subcontract with Connolly Consulting in Region C.



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Selection Process

- CMS does not specify *which* claims the RACs are to review
- CMS does not specify *how* the RACs are to identify claims for review
- Each RAC created their own selection methodology using the knowledge they gained their auditing of healthcare claims from the private sector
- Used past OIG and GAO reports



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Review Process

- CMS will supply the RACs with a data file containing claims data followed by monthly updates
- RACs will use proprietary software to analyze claims for 'possible improper payments'



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Review Process

- RACs can use either:
 - *Automated review* is used when there is 'certainty that the service is not covered or is incorrectly coded'--- (i.e., CPT/HCPC codes deleted), **and** there is a written Medicare policy, article or sanctioned coding guideline exists
 - *Complex review (human review)* is when the medical record is reviewed for determination because 1) the requirements for automated review are not met or 2) there is a high probability (but not certainty) that a service is not covered; or 3) no Medicare policy, article or sanctioned coding guideline exists.



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Items Reviewed

- Medical necessity
- Appropriate coding---both inpatient (DRGs) and outpatient (APCs)
- Duplicate claims
- Incorrect units billed
- Incorrect modifiers that affect payment
- Payment received for deleted HCPC or CPT codes
- Insufficient documentation to support services
- -59 modifier usage



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Items Reviewed

- Transfer versus discharge disposition codes
- High dollar line items
- Use of condition code 44
- Short inpatient stays (1-4 days)
- Appropriateness of place of service---use of observation status
- Non-covered services
- Medical unlikely edits
- Technical denials



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Items Reviewed

- Back pain diagnosis
- Chest pain diagnosis
- Gastro intestinal services --- high volume
- E&M bell curve trending (although initially excluded Physician E&M review some evidence of inclusion---duplicate payments, violations of Medicare's global surgery rules, definition of new patient)
- Modifier -25 with E&M codes
- Durable Medical Equipment (DME)



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Items Reviewed

- Outpatient services
- Physician services
- Admissions to rehab
- Medicare paid based on an outdated fee schedule
- High cost injectable drugs
- Renal dialysis services
- Proper coding for excisional deridements, wound care---who is providing?
- Matching of what hospital billed to what the physician billed



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Items Reviewed

- DRG 475 (respiratory system diagnoses) and DRG 468 (extensive OR procedure unrelated to principal diagnosis)---wrong principal diagnosis
- Wrong diagnosis codes, i.e., septicemia versus UTI, electrolyte imbalances
- Billing the correct number of units for Neulasta
- Billing only one colonoscopy per day



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Items Reviewed

- Billing of speech therapy in per session units versus 15 minute increments
- Three-day stay requirement for inpatient to SNF
- Pain management services
- Cardiovascular interventional radiology; (50-60% coding errors typically)



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Items Reviewed

- If inpatient denied as not medically necessary:
 - Providers may re-bill for ancillary services but ONLY if timeliness rules are met (15-27 months from date of service)
- Billable services listed in:
 - Medicare Benefit Policy Manual



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Items Reviewed

- Skilled Nursing Facilities
 - Medical necessity of the stay
 - Documentation and coding for reimbursement
 - Matching of documentation and billing
 - Consolidated billing issues
 - Therapy documentation and requirements for billing
 - Physician certifications



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Process

- Provider has 45 calendar days to submit requested medical records (may get an extension if inquire within the 45 days)
- RACs pay providers to copy charts at the Medicare rates (may be restricted to inpatient records and long term care records)
- Missing records are automatic denials
- RACs are required to accept imaged records on CD/DVD



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Process

- RACs will be required to advise providers of the results of *automated* reviews only if an overpayment determination is made
- RACs will be required to advise providers of the results of *complex* reviews even if no improper payment is identified
- RACs have 60 days to review a medical record and issue either a notice of improper payment or, in the case of an automated review, a letter stating there is no problem with the claim
- However, the RAC can request an extension in the deadline from CMS and is often granted that extension



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Discussion

- Within **15 working days** of notification of the results, each provider may request a “discussion” with **the RAC**
- Any accompanying evidence must be submitted within **15 working days** from the date of the notification letter
- Discussion should address why the recovery should not be put into effect on the date specified in the notification letter and any additional documentation may be allowed to be submitted



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Appeal Process

- Providers must follow the usual **Medicare** appeal process---requesting a re-determination by filing an appeal within 120 after the overpayment is recouped by Medicare
- Effective July 1, 2008 Medicare can not take payments back if the provider appeals to the first two levels of appeal



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RAC Medicare Appeal Process

- **First Level – Redetermination (Medicare Administrative Contractor)**
 - 0-120 days from RAC initial decision
 - Claim denials or overpayments must be initially appealed to the appropriate Medicare Administrative Contractor by requesting a redetermination of the claim.
 - Medicare Administrative Contractors are required to respond to a provider's request for redetermination within 60 days of receipt.



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RAC Medicare Appeal Process

- **Second Level – Reconsideration (Qualified Independent Contractor)**
 - 0-180 days from Redetermination (First Level) Decision
 - If a provider is dissatisfied with the outcome of the First Level appeal or redetermination process, a request for “reconsideration” may be filed with the appropriate Qualified Independent Contractor (QIC).
 - Requests for reconsideration are required to be processed within 60 days by the QIC.



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RAC Medicare Appeal Process

- **Third Level – Administrative Law Judge Hearing**
 - 0-60 days from Reconsideration (Second Level) Decision
 - **\$120** Minimum amount in controversy
 - If a provider is not satisfied with the Second Level appeal's result of reconsideration, a hearing before an Administrative Law Judge (ALJ) can be requested.



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RAC Medicare Appeal Process

■ Fourth Level – Medicare Appeals Council (MAC)

- 0-60 days from Administrative Law Judge's (Third Level) Decision
 - If the Level 3 appeal and decision by the ALJ is considered unfavorable by the provider, a fourth level appeal request may be filed with the Departmental Appeals Board (DAB) / Medicare Appeals Council (MAC).
 - The MAC must subsequently issue a determination within 90 days of the review.



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RAC Medicare Appeal Process

■ Fifth Level – U.S. District Court Review

- 0-60 days from Medicare Appeals Council (Fourth Level) Decision
- \$1,180 Minimum amount in controversy
 - If the Level 4 decision of the MAC is deemed unfavorable to the provider, the final step in the appeals process is to file suit in U.S. District Court.

Source: www.cms.hhs.gov



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Appeal Process

■ According to the RAC Status Document:

- "in the demonstration project providers chose to appeal only 22.5 percent of the RAC denials"
- "in the demonstration project only 34% of RAC denials were overturned on appeal" – (7.6% of total reviewed)
- The attorneys for the states involved dispute this number saying "over 40 percent were overturned"
- Truth is probably somewhere in the middle!



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Appeal Process

- Submit by overnight mail
- Include the RAC letter requesting the medical record and the RAC notice of overpayment
- Include the initial remit and the remit with the 'take-back' of payment
- Copy of the complete medical record



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Under-payments

If an under-payment is found:

1. RAC will notify Medicare
2. RAC will send a written notice to the provider
3. Medicare will make the adjustment
4. RACs will not forward an underpayment if less than \$1.00



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Over-payments

■ From RAC Website:

- Question: Will Critical Access Hospitals (CAH) be subject to Recovery Audit Contractors (RAC) review? If so, how will the fund be recouped?
- Answer: Yes, Critical Access Hospitals are subject to RAC review. Any adjustments will be reflected on the final PS&R. If the cost report has already had a final settlement, the amount will be demanded and then offset against future claims if not paid in full by the provider.



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Over-payments

- Medicare will use the **recoupment** process---recovery of an outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness---starts within 60 days if not appealed within the first 30 days
- RACs will not attempt to recoup an overpayment of less than \$10 and will not be permitted to aggregate claims of less than \$10 in order to pursue an overpayment
- RACs will be required to offer providers the ability to repay through an installment plan up to 12 months in length (could be longer if CMS central office approves---up to 36 months)



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Over-payments

- Less than 1 percent of the overpayments in the demonstration project have been repaid through installment plans
- If an outstanding debt remains unresolved the debt will be sent to the Department of Treasury for cross-servicing and collection activities
- In the demonstration project less than 5 percent of overpayments were referred to the Department of Treasury



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Interest Payments

- Interest will accrue from the date of the final determination and be charged on an overpayment balance or paid on an underpayment balance for each 30 day period that payment is delayed



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The Big Question

What should we be doing?

- Education, education, education (include physicians)
- Conduct internal and external audits prior to a RAC review (coding reviews, chargemaster review, documentation review to support medical necessity)
- Monitor denials and look for patterns and make changes in chargemaster, coding or documentation as appropriate;
- Review pharmacy billing, J-codes and multipliers for errors



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The Big Question (continued)

What should we be doing?

- Review therapy billing, supporting documentation and the billing of "units/minutes" of service
- Review appropriateness of place of service, i.e. observation, inpatient short stays, 3 day hospital stay requirement for swingbed and SNF admissions
- Review the appropriate use of modifier -59
- Review the coding and documentation for wound care/debridement



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The Big Question (continued)

What should we be doing?

- Review for supporting documentation for E&M visits billed in addition to procedures in ER
- Monitor any previous reports you have received from Medicare or the QIO, i.e. PEPPER reports
- Review the RAC websites for items they are reviewing www.cms.hhs.gov/rac
- Review the OIG Workplan and reports for items to review www.oig.hhs.gov/reports.asp



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The Big Question (continued)

What should we be doing?

- Review the CERT reports for items to review
www.cms.hhs.gov/cert
- Watch remittance advice for code N432 which indicates an adjustment based on RAC review
- Monitor industry publications and attend association meetings, webinars, etc. to keep abreast of the RAC activities
- Learn about the appeals process



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The Big Question (continued)

What should we be doing?

- Participate in RACTrac with your AHA
- Engage some external audits of the chargemaster, coding, and documentation
- Review of ABN process and subsequent claim submission



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The Big Question (continued)

What should we be doing?

- Review of modifier usage
- Review of policy and adherence to policy for appropriate patient status, i.e., inpatient versus observation
- Review medical necessity denials
- Review the work of the Utilization Review staff/case management/discharge planners--- software, criteria



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The Big Question (continued)

What should we be doing?

- Review forms and completion of the forms (admissions, MSP, HIPAA, EMTALA, ambulance, therapy certifications)
- Set up a reserve fund
- Monitor outlier payments for accuracy
- Compare hospital codes with physician codes for the same service (typically a 25% error rate according to the demonstration projects)----RACs have the ability to review and match both
- Do you have any inpatient admissions solely or partially just to achieve a 3-day stay for SNF benefits?
- Review discharge status



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What Do We Need to Know When Under Review?

- CMS RAC team email address: rac@cms.hhs.gov
- Monitor RACs websites:
 - Website will list issues found in RAC reviews
 - January 1, 2010 will be able to review status of claims on CMS website



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What Do We Need to Know When Under Review?

- Listing of RAC contacts:
 - Region A: Diversified Collection Services (DCS), 1-866-201-0580, website: www.dcsrac.com
 - Region B: CGI, 1-877-316-7222, website: <http://racb.cgi.com>, e-mail: racb@cgi.com
 - Region C: Connolly Consulting, Inc., 1-866-360-2507, website: www.connollyhealthcare.com/rac, email: RACinfo@connollyhealthcare.com
 - Region D: Health Data Insights, Inc. Part A: 1-866-590-5598, Part B: 866-376-2319, website www.healthdatainsights.com, e-mail: racinfo@emailhdi.com



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What to do When you get Notified of a RAC Review

- Assign staff to handle RAC requests
- Respond to RAC requests timely (45 days--- otherwise automatic denial)
- File rebuttal (within 30 days) or appeals (within 120 days from take-back)
- Track requests, rebuttals and appeals



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What to do When you get Notified of a RAC Review (continued)

- With each rebuttal or appeal include:
 - the initial RAC letter requesting medical records
 - RAC notice of overpayment
 - Remit for the initial payment
 - Remit for the take-back date
 - Complete medical record
 - Explanation of your position and notation of specific areas in the record that support your position
 - Mail by overnight mail
 - Stay in contact with the RAC reviewers



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RAC Reviews

- Miscellaneous Issues
- Questions??



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