



WHA Recovery Audit Contractor Forum
August 11, 2009

Questions

A. RAC Contacts

1. Who are the RAC contacts for hospitals at both the CMS and CGI?
2. Where will RAC reviewers be based?
3. How will CGI obtain RAC contact information at hospitals and keep it updated?

B. Provider Communication

4. How often will CGI provide update forums, either in-person or via audio conference?

C. RAC Process and Procedures

5. PRG Schultz is your subcontractor in Wisconsin. Can you describe how that will work and how it is different than your RAC activities in other states?
6. Will CGI policy and procedures for handling requests, recovery and appeals be accessible electronically or otherwise?
7. Where will hospitals go to find the automated reviews... the CMS RAC site or the CGI website?
8. What is the draft timeline for requests, appeals, and payment recoveries/reimbursement adjustments?
9. What is the contract duration between CGI and the CMS?
10. Will CGI be following the CMS Statement of Work for the Recovery Audit Contractor Program published Nov. 7, 2007?
11. When will CGI have the secure line to the CMS to receive claim information for Wisconsin's facilities from Oct. 1, 2007, forward?
12. Will CGI begin with smaller batch sizes to acclimate both CGI and Wisconsin hospitals to the RAC process?
13. Is there a central address that all requests for records are sent?
14. What patient identifier will the RAC be using (i.e. patient account number, medical record number)?

15. How are the requests going to come to us (e.g. one patient per letter or a listing of patients)? Will CGI include the patient's name and date of service?
16. If a provider record has been challenged by the fiscal intermediary (FI) on an earlier date and the RAC is seeking the same record, how does the provider notify the RAC that the record was already scrutinized by a Medicare contractor or that recovery is currently in process?
17. If we have a request involving a record that has previously been reviewed by another audit previously performed by Medicare - what is the most effective method of informing CGI?
18. Are records that the provider previously self reported an error excluded from RAC review?
19. Will extrapolation be used? If so how will the provider be informed and what are the guidelines regarding secondary insurance and patient payments?
20. What procedure does CGI plan to use to coordinate payment take-backs with National Government services, the FI for Wisconsin? Will these take backs appear on a separate voucher that clearly identifies they are the result of a RAC audit?

D. RAC Focus

21. What issues will CGI submit for CMS approval?
22. Will the RAC tell us their areas of focus?
23. How frequently will CGI post focus area updates to their Web site?
24. Are there particular categories of hospitals on which CGI will focus its initial review (large hospitals, teaching programs, critical access hospitals)?
25. Will same day surgeries be included in the RAC audits?
26. Will the RAC review only Medicare fee-for-service claims or also Medicare Advantage claims?
27. How is discharge status "Discharged to Home Health" applied? Just if referred to Home Health? What if the subsequent Home Health evaluation determines that the patient does not qualify? What if the patient refuses the services after discharge? What is the Hospital's responsibility and how can this be effectively monitored?
28. Are the claims under review those that are incurred Oct. 1, 2007, or claims that are paid Oct. 1, 2007, or later?
29. What about hospital underpayments?

E. CGI Requests and Reviews

30. When can we expect the first RAC record requests?
31. Will there be an e-mail to notify hospitals if a letter is on the way?

32. Once a hospital receives a request from CGI, how long will they have to respond?
33. From what date does one count to ensure records are sent within 45 days?
34. What is the maximum number of records that CGI will be requesting from a hospital at any given time?
35. With respect to medical record limits, could you clarify if the physician limit will include claims for non-physician providers?
36. What is the desired method of payment... recoupment or check?
37. Regarding the medical record request limitations, since PPS hospitals are paid on APCs, what will CGI define as an outpatient service? Will an outpatient service be based on a line item, or will an outpatient service include the entire outpatient claim?
38. Please clarify under what formula medical record requests for Observation cases will be calculated. Will observation be calculated in "inpatient hospital" or "other Medicare Part A billers"?
39. Please clarify the term "services" for the RAC medical record request limits for "other Part A Billers". The RAC medical record request limits states that for other Part A Billers, 1% of average monthly Medicare services (max of 200) per 45 days may be requested for review. Is services based on episode of care or individual service codes? For example, outpatient procedure is performed on 1/1/09 and 3 CPT codes are submitted for reimbursement. Is this 3 services because there are 3 codes or is this 1 service because all were performed during the same episode of care?
40. Will RAC medical record request letters indicate the target area for which the case is being reviewed?
41. I understand that the provider will have 45 calendar days to submit medical records and that a second request will be sent. What is the time period for the RAC to send the second medical record request?
42. If a hospital uses an electronic medical record (EMR) system, what documentation will be required to provide to CGI?
43. Will the RAC be accepting electronic "copies" of records? If so, what are the guidelines, format, labeling requirements, etc?
44. How will the EMR be used? Can hospitals grant access to CGI for selected cases?
45. Will CGI accept medical records in electronic format from a copy service?
46. Are hospitals required to notify the RAC that a record has been submitted?
47. What method does CGI want the provider to report when records have been sent? E-mail? Phone call? US mail?
48. How are hospitals notified that a record has been received?
49. For claims identified by the automated review process, what options does a hospital have to dispute prior to denial?

50. For claims identified by the automated review process, when will cash be recovered?
51. What is the maximum number of CGI staff members who could be physically present at my hospital?
52. How often will CGI conduct on-site hospital review?
53. Will there be advance notice of on-site hospital reviews?
54. If a record is reviewed on-site, will the RAC request copies of the record to take with them?
55. Does CGI plan to perform on site reviews? If yes, does a provider have the option of denying an on site review?
56. What cases will be reviewed by the RAC medical director?
57. What utilization criteria will CGI be using to review for medical necessity, InterQual, Milliman or another?
58. We understand the CGI has purchased the Interqual license. Since other RACs have purchased both criteria licenses, can we expect that CGI will too purchase both, especially since the Wisconsin QIO (MetaStar) utilizes Milliman?
59. Will CGI take into account both national coverage decisions and local coverage decisions prior to their initial determination?

F. Disagreements and Denials

60. If a hospital disagrees with the CGI determination, what is the procedure for the hospital to discuss the situation with CGI prior to the denial?
61. What justification will be included on the denial letters?
62. Will CGI accept physicians' notes from their offices to support the request for service i.e. testing/results performed prior to admission to support the need for the procedure?
63. What documentation will CGI accept during the 15 days after the denial letter to support the hospital's position that the case qualified for inpatient admission status?
64. Will there be unique voucher denial codes for denials originating from RAC reviews?
65. If an inpatient claim is denied, can the hospital re-bill the ancillary services?
66. Are you allowed to create physician queries for clarification once the RAC denied a claim?
67. For inpatient cases that are determined to be not reasonable and medically necessary, our understanding is that providers can rebill for Inpatient Part B services that are on the list in the Benefit Policy Manual and if all claim processing rules and claim timeliness rules are met. Rebilling timeframes range from 15-27 months. Given the RAC 3 year look back period, this time period may have expired when RAC review begins and/or results in denial of payment. Will any consideration be given to extending the period for rebilling of Part B services for RAC denials?

68. For a case that is denied due to failure to submit a medical record and documentation is later submitted, will the provider need to dispute the denial through a first level of appeal process or is there a different manner in which this will be processed?
69. If CGI denies a hospital claim for services, will it also deny the physician claim for services?
70. How does the N432 Remittance Advice correlate with the recoupment process? For example, for claims identified by the automated review process, when will the N432 be sent to providers and when will money be recovered? Will N432 be used in both activities or will the N432 be sent prior to adjusting?
71. Could you provide a sample N432 remittance advice?
- a. What CAS code would accompany N432 on the remittance advice? The N432 is not a stand alone code.
 - b. We are looking for N432 clarification to facilitate how we can match up the Demand Letter with the remittance advice. If there are multiple N432s, we have to find a way to match up the N432s with Demand Letters knowing the letter is what starts the appeal timeline.
 - c. What is the process providers (facilities) follow when a Demand Letter is received and no N432 remittance advice has been sent?
72. Can you provide a sample medical record (complex review) request?

G. Appeals

73. What will the recoupment plan be for CAHs, when the cost report is settled? When the cost report is not yet filed?
74. If a hospital disagrees with the CGI determination, what is the procedure for the hospital to appeal? What is the timeframe to appeal?
75. If a hospital misses the date to submit a record for an initial request and receives a technical denial, does it have another opportunity to submit?
76. What is the process for automated denials? Can they be appealed?
77. Will the health system be able to submit appeals on behalf of its hospitals?
78. Who needs to sign the appeal letter? Does the appeal letter have to be an original or can it be a faxed or printed copy?
79. On appeal, may the provider include information from, for example, the physician's office record or other data supporting the coding or medical necessity for the service that was not otherwise found in the provider record?
80. Does interest on overpayments accrue during the appeal process?

H. Correspondence to Hospitals

81. Will CGI use regular mail, UPS or Fed Ex, or e-mail to send notices for medical record requests?
Results of medical record reviews? Notice of automated review? Notice of recovery amount?
82. What will the letterhead look like?
83. Will the RAC accept records electronically? If so, in what format? Are there encryption rules? If so, what are they?
84. Can hospitals charge for the postage and/or envelopes if they have to provide them?
85. Will the RAC provide return envelopes for each individual record?
86. Will hospitals (PPS and CAHs) be reimbursed for copying costs?
87. How does the RAC want the bills for record copying made out and where should this bill be sent?
88. How is the copy cost sent to the provider?