RAC Reality Check: What Physicians Really Need to Know

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Agenda

1. Introduction/ Review
2. RAC Reality Check
3. Debunking the Myths
4. Getting It Right The First Time
Recovery Audit Contractors

• Independent contractors
  – Medicare Claim RAC
  - Medicare Secondary Payer RAC
• Paid on contingency basis

“CMS did not establish an adequate process …to address RAC-identified vulnerabilities that led to improper payments, such as paying duplicate claims for the same service”.

General Accounting Office
GAO-10-143 March 31, 2010
Recovery Audit Contractors

- Patient Protection and Affordable Care Act (Effective 12/31/10)
  - Medicaid
  - Medicare Parts C & D

50 different Medicaid RACs?
Purpose

• Detect and correct Medicare improper payments
  – Refund overpayments
  – Collect underpayments (recoupment)
  – Refer suspected fraud

3 Year Demonstration → Permanent Program
RAC Reviews

Types of RAC Reviews

Automated ("Clear" Issues)
- Automatic refund "request" w/o notice

Complex (" Likely"
- Medical record request
- Claim review & determination notice

Coding Errors

- Improper Payment
- Medical Necessity
- Difference In Interpretation
- Duplicate Claims
- Mistake In Payment
- Documentation
RAC Determinations

- **Coverage** – if service is not covered the RAC can identify partial or full overpayment
  - Ø reasonable/necessary, excluded

- **Coding** – if service coded incorrectly the RAC can identify partial or full over or under payment
  - Ø CPT, coding guideline/article, etc.

RAC Determinations

- **Other** – the RAC can identify partial or full over or under payment for other conditions
  - Failure to apply correct payment policy
  - Duplicate claim submission
RAC Determinations

- Wrong diagnosis or Excessive/multiple units billed improperly
  - Difference between correct & incorrect payment

- Medically Unnecessary
  - Full recoupment

RAC Reality Check

Part A vs. Part B Audits & Impact on Physician Practices
Permissible Scope

Reality Check – Permissible Scope
- Part A (hospital) and Part B (supplemental)
  - Hospitals
  - Physicians
  - Practitioners
  - LTC facilities
  - DME suppliers

Part “A” Approved Issues
- DRG validation (Hospital claim = attending physician description + MR)

Examples:
- Wound debridement
- Kidney & urinary tract procedures
- …etc.
Part “B” Approved Issues

- Outpatient therapy services
- IV hydration therapy
- Newborn services > age parameters
- …etc.

Source of Overpayments (%)

Physician Overpayment: ~$20M

- Inpatient Hospital: 84.19%
- Inpatient Rehab: 6.07%
- SNF: 4.25%
- SNF: 2.5%
- Outpatient Hospital: 1.76%
- SNF: 0.51%

Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration (June, 2008)
DEBUNKING THE MYTHS

Myth No. 1

- Part B services will be not be audited by the RACS
Fact

• If you bill fee-for-service programs, your claims will be subject to review by the RACs

“…for those physicians who were audited, the process was extremely disruptive, costly, and very burdensome”
American Medical Association

Myth No. 2

• Inpatient Evaluation and Management codes are off limits to RAC auditors
Fact

Q: Will the Recovery Audit Contractors (RAC) review evaluation and management (E&M) services on outpatient hospital claims?

A: Yes

CMS Frequently Asked Questions
www.questions.cms.hhs.gov

Myth No. 3

Myth No. 3:

RACs can request and review any claim, no matter how old the claim is
Fact

“Look-Back” Period

3 Years

> October 1, 2007

Myth No. 4

Myth No. 4:

Providers can expect to be overloaded just by the sheer number of records requested by their RAC
### Number of Records per TIN

<table>
<thead>
<tr>
<th>Type</th>
<th>Records</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practitioner</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Partnership (2-5)</td>
<td>20</td>
<td>45</td>
</tr>
<tr>
<td>Group (6-15)</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Large Group (16+)</td>
<td>50</td>
<td>45</td>
</tr>
</tbody>
</table>

### Provider A – Single Entity

- TIN 123456789
- 2 physical locations (12345, 12346)

### Provider B – Two Entities

- TIN 123456780
- 2 physical locations (12345, 21345)
Myth No. 5

A proper RAC decision cannot be re-billed to Medicare

Fact

RAC decisions can – and should – be re-billed where appropriate

Example

- Overpayment for Echocardiogram billed as if in inpatient setting
- Correct setting: Office setting
  (Assumes statute of limitations has not passed)
Myth No. 6

• The RAC determination decisions are made by people who are unfamiliar with the complexities involved in either providing medical care or in Medicare’s billing requirements

Fact

Demonstration Project
• No Medical Director
• Certified Coders not required

Permanent Program
• Medical Director for every RAC
• Must confer upon request
• Certified Coders
• External validation process
Myth No. 7

• The RACs don’t have to refund their contingency fees if they’re wrong

Fact

**Demonstration Project**
• Refund fees only if overturned at 1st level of appeal

**Permanent Program**
• Refund fees at any level of appeal
Myth No. 7

- I can get RAC insurance from a commercial carrier

Fact

RAC Audit Insurance

Appeal Insurance
GETTING IT RIGHT THE FIRST TIME

What do I need to be doing now to prepare?

Preparation

Evaluate & Focus
Plan & Implement
Identify Vulnerabilities

Manage
Evaluate & Focus

1. Find out what region your state is assigned to.

RAC Jurisdictions

What color is your state?

[Diagram showing the RAC Jurisdictions with states color-coded into regions labeled HDI, CGI, DCS, and CCG.]
### RAC Contingency Fees

<table>
<thead>
<tr>
<th>RAC Region</th>
<th>Contingency Fee %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>12.45%</td>
</tr>
<tr>
<td>B</td>
<td>12.50%</td>
</tr>
<tr>
<td>C</td>
<td>9.00%</td>
</tr>
<tr>
<td>D</td>
<td>9.49%</td>
</tr>
</tbody>
</table>

### Evaluate & Focus

- **RAC Region A: DCS Healthcare (DCS)**
  - Subcontractors: PRG Shultz, iHealth Technologies and Strategic Health Solutions
- **Region B: CGI Federal (CGI)**
  - Subcontractor: PRG Schultz
- **Region C: Connolly Consulting Group (CCG)**
  - Subcontractor: Viant, Inc.
- **Region D: Health Data Insights (HDI)**
  - Subcontractor: PRG Schultz
Evaluate & Focus

2. Access Websites
   - Identify approved issues on RAC website
     (state and issue specific)
     • Tracking tools
Evaluate and Focus

CGI (Region B)
• Added medically unlikely edits for outpatient and professional claims review (all)

HDI (Region D)
• Removed approved issue “Anesthesia Care package E/M Service” (all)

Evaluate & Focus

2. Access Websites
   – Identify approved issues on RAC website (state and issue specific)
     • Tracking tools
   – CMS website
     www.cms.hhs.gov/rac

Effective Friday, April 2: www.cms.gov
Identify Vulnerabilities

1. Identify Inefficiencies
   – Conduct improper payments: claims analysis
   – Review claims before submitting
     • Chart documentation
     • Accurate coding
2. Identify Vulnerabilities
   – Conduct prospective audit/assessment
     • Prospective
     • Retrospective under attorney/client privilege
     • Consider 3rd party reviewer
       – Involve both clinical & administrative staff
   – Implement corrective actions (false claims issue)
   – Consider self-reporting (cannot be reviewed)
Identify Vulnerabilities

3. Identify Sources of Improper Payments

- OIG Reports
- CERT Reports
- Claim Denials
- RAC/CMS Website
- CPT & HCPCS II Codes
- OIG Reports

Identify Practice Specific Vulnerabilities

www.cms.hhs/rac

www.oig.hhs.gov/reports.html

www.cms.hhs/cert
CMS “RAC 101” Call

• Nationwide RAC 101 Call for Physicians
  – May 12, 2010 1:00pm - 2:30pm EST
  – 1-877-251-0301, meeting ID: 66529242

http://www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage

http://www.youtube.com/watch?v=IHFXsfP99Bc
Identify Vulnerabilities

- CPT & HCPCS II Codes
- OIG Reports
- RAC/CMS Website (www.cms.hhs/rac)
- Claim Denials
- CERT Reports (www.cms.hhs/cert)

Plan and Implement

1. Proactively promote appropriate documentation
   - Clear clinical status
   - Presenting symptoms
   - Rationale for care
   - Treatments provided to improve patient’s clinical status
   - Influencing factors
2. Educate & train
   - Real world examples
   - Certified professionals
     • Involve administrative & billing staff

2. Educate & train, contd.
   - Current resources
     • Manuals
     • National coverage determinations (NCD)
     • Local coverage determinations (LCD)
2. Educate & train, contd.
   – Diagnostic coding
     • “Rule out”, “Possible”, or “Probable” symptoms
     • Chronic conditions

3. Attack Low Hanging Fruit
   – Clinical findings in support of medical necessity
   – Include modifiers
Plan and Implement

4. Sign up to email notification lists to receive up to date information
   - CMS RAClistserve

Plan and Implement

5. Designate a Compliance Officer
Plan and Implement

6. Assign primary responsibility for RAC responses & **notify your RAC**
7. Educate staff to recognize RAC correspondence

Plan and Implement

8. Establish policies/procedures
   - Prepare extension request template
   - Establish appeal determination process
   - Prepare appeal template letters

*AHIMA Recovery Audit Contractor (RAC) Toolkit 2009*
What should I do when the auditors come knocking?

Record Request

• Automated Review
  – No records request (claims review)

• Complex Review
  – 45 day response (+ extension)
  – Additional contact x 1 >60 days
Process

Provider
• Medical Record Request

RAC
• Response within 45 days (or automatic denial)

RAC
• RAC determination (60 days)

Record Request

1. Track and monitor all correspondence - log and date stamp date received
2. Begin tracking 45 day response
3. Sequentially number medical record pages

4. Include original request letter (copy)

5. Save electronic/duplicate copy

6. Submit clear/complete documentation for all services
   - Injection order by Nurse Practitioner
   - Injection administration by Medical Assistant
Record Request

7. Full and complete record
   – Signature sheet

8. Certified/Return Receipt

Recoupment Notice Received

1. **Log and date stamp** the day request is received
   – Demand Letter (Automated Review)
   – Discussion Period

   – Review Results Letter (Complex Review)
   – Discussion period
Recoupment Notice Received

1. **Log and date stamp** the day request is received
   - Demand Letter (Automated Review)
   - Discussion Period
   - Review Results Letter (Complex Review)
   - Discussion period

   Reason Code: N432

2. Determine if you agree with the determination
   - Proper coverage & payment policies applied?
   - Within RACs scope of review?
     - Processed & appealed
     - Reported improper payments
– Agree
  • Pay on or before day 30 (check)
  • Allow recoupment from future payments (interest accrues)
  • Request extended payment plan (interest accrues)

• Re-bill as indicated
  http://www.cms.hhs.gov/manuals/Downloads
  • Retroactively recoup from the patient (with a proper ABN)
Recoupment Letter Received

- Disagree
  - Rebut (15 calendar days)
  - Appeal (CMS-20027)
    - www.cms.hhs.gov/CMSForms
  - Include supporting documents

To Appeal or Not To

Max Time to File Initial Appeal: 120 days

Reference documentation to refute the denial

• Determination letter
• Detailed reasoning
• Highlighted record
Appeal Decision Criteria

- Minimum claim-dollar threshold based on administrative costs to appeal
- Availability of resources
- Quality of medical records, charts and other documentation
<table>
<thead>
<tr>
<th>Level</th>
<th>Process</th>
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<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Redetermination (Carrier)</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>Reconsideration (QIC)</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>ALJ Hearing (Medicare Office of Hearing &amp; Appeals)</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Review (Medicare Appeals Council)</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Judicial Review (Federal Ct.)</td>
</tr>
</tbody>
</table>

Submit Additional Documentation
• Remember to track **all** correspondence!
• Electronic/duplicate copy

• Keep track of denied claims
• Look for patterns
• Determine what corrective actions you need to take to avoid improper payments
• Collect repayment + interest!

VISIT YOUR RAC WEBSITE AT LEAST WEEKLY

Evaluate & Focus

Plan & Implement

Identify Vulnerabilities
UHSEC RAC Action Plan

Staffing

- Corporate: + 1 FTE
- PCMH: +1 FTE
- Regionals: Existing
Responsibility

- Centralized Process
  - Office of Audit & Compliance
  - Team Leader
- Facility Teams
  - Compliance Officers
  - OAC Staff
  - HIMS
  - IS
  - UR
  - Financial Services

Correspondence

- Installed a dedicated phone
- Installed a dedicated fax line
- Set up a dedicated Post Office Box
  - Direct mail delivery
RAC Notification

- Facilities
  - RAC notifies facilities of automated reviews

- UHS OAC
  - Receive any paper requests from RAC

Information Systems

- Created a shared “work in progress” drive that all UHS entities can access (WIP)
Tracking RAC

- **RAC Tracking Software**
  - Add-on feature to existing financial software

- **Software Training**
  - OAC staff
  - Facility Representatives

- **Reports & Alerts**
  - Streamline the RAC Process
  - User-friendly

Patient Data Testing

- **Test patients identified**
- **Each facility submitted test medical records to the Work In Progress (WIP) folder**
- **Encryption and burning of CDs**
Testing Issues Identified

• Medical Records
  – Blank/Upside down pages
  – Scanning of Attestation Sheet
  – Multiple copies of the same document

CD Submission Test

• Provider list containing:
  – Provider Name
  – Medicare Provider Number
  – Medicare Group Number
  – Tax ID Number
  – NPI
Complex Review – Case No. 1

- Number of records: 139
- Excluded: 3
Complex Review – Case No. 1

- Underpayment $17,059
- Overpayment -206,067

Net: - $189,008

Response

- DRG specific education
- Billing system modified
- Appeals pending
Questions

aerosol