The Recovery Audit Contractor (RAC) Initiative:
What health care organizations need to know and what they can do to prepare

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Overview of the RAC Initiative: The Demonstration Project

- Section 306 of the Medicare Modernization Act directed CMS to investigate Medicare claims payments using RACs under a three year demonstration project
  - MSP RAC
  - Claim RAC
- California, Florida and New York were chosen for the demonstration project focusing on services provided from October 1, 2001 - September 31, 2006
- RAC Pilot began during the Spring 2005 and will end in March 2008.
Overview of the RAC Initiative
The Demonstration Project

FY 2006 RAC Status Report identified $299.5 million in “inappropriate” payments
- $289.1 million in overpayments
  - $64.6 million collected
  - $224.5 million “in the queue”
- $10.4 million in underpayments
  - $2.9 million paid back
  - $7.5 million “in the queue”
- $14.5 million in overall costs ($12 million in contractor fees $2.5 million in administrative costs)

FY 2007 RAC Status Report identified $371.5 million in “inappropriate” payments
- $357.2 million in overpayments
  - $ million collected
  - $ million “in the queue”
- $14.3 million in underpayments
  - $ million paid back
  - $ million “in the queue”
- $77 million in overall costs ($71.2 m contractor fees and $5.5 m in administrative costs)
- $17.8 million in appeals overturned
Overview of the RAC Initiative
The Demonstration Project

Table 2-1
Summary of Total Improper Payments Corrected By The RAC Program – FY 2007

<table>
<thead>
<tr>
<th></th>
<th>Overpayments Collected</th>
<th>Underpayments Repaid</th>
<th>Total Improper Payments Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>$122.5 m</td>
<td>-</td>
<td>$144.3 m</td>
</tr>
<tr>
<td>Florida</td>
<td>$124.5 m</td>
<td>- $4.1 m</td>
<td>$128.7 m</td>
</tr>
<tr>
<td>California</td>
<td>$120.1 m</td>
<td>- $8.4 m</td>
<td>$128.5 m</td>
</tr>
<tr>
<td>Total</td>
<td>$357.2 m</td>
<td>- $14.3 m</td>
<td>$371.5 m</td>
</tr>
</tbody>
</table>

SOURCE: RAC Data Warehouse. $ in millions

Overview of the RAC Initiative
The Demonstration Project

FY 2006 RAC Status Report, pg. 18
“achieved a respectable return on investment of 373% in 2006”

FY 2007 RAC Status Report, pg. 21
“achieved a respectable return on investment of 318% in 2007” – “cost of 22 cents for each dollar collected”
Overview of the RAC Initiative
The Demonstration Project FY 2007

<table>
<thead>
<tr>
<th>Table 2-3</th>
<th>OVERpayments Collected By Provider Type and Jurisdiction – FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient Hospital and SNF</td>
</tr>
<tr>
<td>New York</td>
<td>$99.2 m</td>
</tr>
<tr>
<td>Florida</td>
<td>$105.1 m</td>
</tr>
<tr>
<td>California</td>
<td>$95.5 m</td>
</tr>
<tr>
<td>Total</td>
<td>$312.8 m</td>
</tr>
</tbody>
</table>

SOURCE: RAC Data Warehouse, (Physician to Ambulance, Lab, Other: same as derived from self-reported RAC data; m = million)

Overview of the RAC Initiative
The Demonstration Project FY 2007

<table>
<thead>
<tr>
<th>Table 2-5</th>
<th>Overpayments Collected By Error Type (NET OF APPEALS) – FY 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient Hospital and SNF</td>
</tr>
<tr>
<td>Incorrectly Coded</td>
<td>$123.8 m</td>
</tr>
<tr>
<td>Med. Unnecessary</td>
<td>$106.5 m</td>
</tr>
<tr>
<td>NonInsufficient Doc</td>
<td>$29.5 m</td>
</tr>
<tr>
<td>Other</td>
<td>$44.8 m</td>
</tr>
<tr>
<td>Total</td>
<td>$294.7 m</td>
</tr>
</tbody>
</table>

SOURCE: Self-reported by RACs; m = million
Overview of the RAC Initiative  
The Demonstration Project

Table 2-4  
UNDERpayments Paid Back By Claim Type and Jurisdiction – FY 2007

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Hospital and SNF</th>
<th>Outpatient Hospital</th>
<th>Physician</th>
<th>Ambulance, Lab, Other</th>
<th>Durable Medical Equipment</th>
<th>Total UNDERpayments Nonpaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>$1.2 m</td>
<td>$0.4 m</td>
<td>$0.2 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$1.8 m</td>
</tr>
<tr>
<td>Florida</td>
<td>$4.1 m</td>
<td>$&lt; 0.1 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$4.1 m</td>
</tr>
<tr>
<td>California</td>
<td>$8.3 m</td>
<td>$&lt; 0.1 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$8.4 m</td>
</tr>
<tr>
<td>Total</td>
<td>$13.6 m</td>
<td>$&lt; 0.1 m</td>
<td>$0.2 m</td>
<td>$0.0 m</td>
<td>$0.0 m</td>
<td>$14.3 m</td>
</tr>
</tbody>
</table>

SOURCE: RAC Data Warehouse (Physician & Ambulance/Lab/Other not derived from reported RAC data). 0 = n/a.

Overview of the RAC Initiative  
The Demonstration Project

Table 3-1  
Provider Appeals of RAC-initiated Overpayments – Cumulative through FY 2007

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Part C &amp; D</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY</td>
<td>66,647</td>
<td>74,334</td>
<td>141,063</td>
</tr>
<tr>
<td>FL</td>
<td>46,176</td>
<td>65,116</td>
<td>111,292</td>
</tr>
<tr>
<td>CA</td>
<td>46,669</td>
<td>49,045</td>
<td>95,714</td>
</tr>
<tr>
<td>Total</td>
<td>162,132</td>
<td>163,529</td>
<td>325,661</td>
</tr>
</tbody>
</table>

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There is a delay between the time when an appeal is filed and when it is reported to CMS. The table reflects all appeals that had been filed on or before 12/31/07 and communicated to the RAC by the 15th of the month. The table includes a number of appeals that were filed after 1/15/08 but were not reported to the RAC until 2/15/08. In addition, this table does not reflect claims determinations made in appeals filed after 12/31/07. The final column in this table is a count of all appeals filed through 1/15/08. The table may not reflect new data or new appeals filed after 12/31/07.
Overview of the RAC Initiative
The Permanent Program

- Section 302 of the Tax Relief and Health Care Act of 2006, the RAC pilot is being expanded to all 50 states by 2010 employing 4 RACs to cover 4 region
- CMS will announce the 4 permanent RACs during the spring of 2008
- RAC will supplement, not supplant other review efforts by Fiscal Intermediaries, Part B and DME Carriers, Program Safeguard Contractors (PSC), Benefit Integrity Support Centers (BISC) Quality Improvement Organizations (QIO) or the Office of Inspector General (OIG)

Future RAC Jurisdictions
Potential Barrier to Implementation

- On November 7, 2007, House Representative Lois Capps introduced the Medicare Recovery Audit Contractor Program Moratorium Act of 2007 (H.R. 4105). If enacted, H.R. 4105 would suspend all further activities under the RAC program for a period of 1 year following enactment. H.R. 4105 has been referred to the House Ways and Means and the House Energy and Commerce committees, and currently has 40 co-sponsors.
Mechanics of the RAC Process

Mechanics of the RAC Initiative

- CMS Payments to RACs
  - Contingency basis for all accurately identified overpayments
  - Percentage basis for all "partial" underpayments identified and recovered
Mechanics of the RAC Initiative

• Selection of Claims for Review
  – Must “target” claims through data analysis
  • Cannot randomly select claims*
  • Cannot just focus on high payment claims

* Section 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 prohibits the use of random claim selection for any purpose other than to establish an error rate

Mechanics of the RAC Initiative

• Types of RAC “Targeted” Reviews
  – Automated – No medical records involved in the review, certainty that overpayment exists based on data review
  – Complex – Medical records are involved in the review, high probability (but not certainty) that the service is not covered
Mechanics of the RAC Initiative

• Claim Review Period
  – No claims processed prior to October 1, 2007 will be reviewed, regardless of when your RAC begins
  – Going forward, RAC will not be able to look back more than 3 years after claim processing date (originally 4 years during the demo project)
  – RACs will be receiving newer data each month
  – RAC no longer has to wait one year from processing date to review (originally had to wait 1 year from processing date to allow other affiliated contractors first dibs)

Mechanics of the RAC Initiative

• RAC Record Requests
  – Facility responsibilities
    • Respond to request for records within 45 days
    • Request an extension prior to the 45\textsuperscript{th} day RAC
    • Determine how much medical record to send
Mechanics of the RAC Initiative

- RAC Record Requests
  - RAC Responsibilities
    - All medical request letters must “adequately” describe the good cause for reopening the claim
    - Prior to denying a claim for failure to submit MR, RAC must initiate one additional contact
    - Shall develop the necessary processes to accept imaged medical records sent on CD or DVD beginning immediately and sent via the 277 transaction record starting in 2010 (in addition to faxes and hard copies)
    - RAC has 60 days to approve or deny a service or request an extension from CMS

- Requirements for permanent RACs that did not exist under the demonstration project but will be present now
  - Medical Director required (no requirement previously)
  - Clinicians make coverage/medical necessity and certified coders make coding determinations
  - AC Validation Process (was optional before)
  - Standardized medical record request letters (not previously addressed)
  - Record request limits
  - Payment for medical records (IP & LTC)
Mechanics of the RAC Initiative

• **Enhanced** Claim Review Conditions
  – Before reopening a claim, the RAC must have “good cause” in accordance with Reopening Regulation 42 CFR 405.980
  – “Good cause” may include, but not be limited to:
    • OIG report findings
    • Data analysis findings
    • Comparative billing analysis

• RACs may **not** attempt to identify improper payments arising from:
  – services provided under a program other than Medicare fee-for-service;
  – the cost report settlement process;
  – claims more than 3 years past the initial determination date;
  – claim paid dates earlier than October 1, 2007;
Mechanics of the RAC Initiative

- RACs may **not** attempt to identify improper payments arising from (cont’d):
  - claims where the provider is without fault;
  - the random selection of claims;
  - claims with special processing numbers (e.g., claims in Medicare demonstrations); or
  - prepayment review.

Mechanics of the RAC Initiative

- **Services not available for RAC Review**
  - Excluded Services - previously evaluated by an “Affiliated Contractor (AC)” (QIO, FI, Pt B or DME Carrier)
  - Suppressed Services - being investigated as part of potential fraud cases by Benefit Integrity Program Safeguard Contractors “Benefit Integrity Contractor (BIC)” or law enforcement agency
- Coordination of Contractor Reviews through the “RAC Data Warehouse”
Mechanics of the RAC Initiative

- Services not included in RAC Review
  - Cost report settlement issues (i.e., IME or GME)
  - Part B Carrier Evaluation and Management (E&M) services incorrectly coded (99201-99499), except*:
    - E&M services that are not reasonable and necessary
    - Violations of Medicare global surgical billing and payment rules
  - Medicare Managed Care, Medicare drug card or drug benefit program services

- Appealing Denials – Standard CMS timelines based on when money is taken back, not when letter is received
  - Rebuttal
    - Hospital notifies RAC that it disagrees with determination within 15 days of receipt of notification
  - Levels of the Medicare Appeals Process
    - Redetermination through FI
    - Reconsideration through QIC
    - Hearing before an ALJ
    - Review by the Medicare Appeals Council
    - Judicial Review (U.S. District Court)
Mechanics of the RAC Initiative

• Appealing Denials
  – Under the Demonstration Project, the RAC lost their contingency fee only if the appeal was overturned during the initial appeal process (redetermination), regardless of whether it was overturned at a higher level.
  – Under the new SOW – the RAC will lose their contingency fee if the denial is overturned at any level of appeal.

Tips for Preparing for RAC
2006 CMS RAC Status Report

Observations

• National Areas of Focus and Type of Review:
  – Inpatient
    • Debridement (complex)
    • Respiratory Failure (complex)
    • Medical back pain (complex)
  – Transfusion codes (automated)
  – Speech therapy (automated)
  – Neulasta (complex)

RAC Findings FY 2006

<table>
<thead>
<tr>
<th>Inpatient Hospital Services</th>
<th>Overpayments Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin graft &amp;/or debridement for skin ulcer or cellulitis (263)</td>
<td>$3.9 million</td>
</tr>
<tr>
<td><strong>Incorrect</strong>: Provider billed for “excisional” debridement but medical record does not support the procedure.</td>
<td></td>
</tr>
<tr>
<td>Wound debridement and skin graft, exc. Hand for musculoskeletal and connective tissue disease (217)</td>
<td>$13.9 million</td>
</tr>
<tr>
<td><strong>Incorrect</strong>: Provider billed for “excisional” debridement, medical record fails to support the procedure.</td>
<td></td>
</tr>
<tr>
<td>Medical back problems (243)</td>
<td>$2.0 million</td>
</tr>
<tr>
<td><strong>Not Medically Necessary</strong>: Services could have been provided as an outpatient (probably represent causes where the provider admitted the beneficiary for 3 days to qualify for SNF coverage)</td>
<td></td>
</tr>
</tbody>
</table>
### RAC Findings FY 2006

<table>
<thead>
<tr>
<th>Non-Inpatient Hospital Services</th>
<th>Overpayments Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection, pegfilgrastim (Neulasta) 6mg (J2505)</td>
<td>$0.5 million</td>
</tr>
<tr>
<td>Incorrect: Provider billed one service per 1mg but definition of code is one service per 6mg vial.</td>
<td></td>
</tr>
<tr>
<td>Speech/hearing therapy (92507)</td>
<td>$0.4 million</td>
</tr>
<tr>
<td>Incorrect: Provider billed one service for each 15 minutes but definition of this code is one service per session.</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion service (36430)</td>
<td>$2.4 million</td>
</tr>
<tr>
<td>Incorrect: Provider billed one service per pint of blood but definition of this code is one service per transfusion session (usually once per day).</td>
<td></td>
</tr>
</tbody>
</table>

### 2007 CMS RAC Status Report

**Observations**

- **National Areas of Focus and Type of Review:**
  - Inpatient
    - Debridement (complex)
    - Respiratory Failure (complex)
    - Vents (complex)
    - Rehab services (complex)
  - Transfusion codes (automated)
  - Colonoscopy (complex)
  - Speech therapy (automated)
## 2007 CMS RAC Status Report Observations

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Description of Item or Service</th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Cases Overturned on Appeal</th>
<th>Location of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>Excisional Debridement</td>
<td>$30.6 m</td>
<td>2,603</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3.2 m</td>
<td>420</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2.5 m</td>
<td>346</td>
<td>FL</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>IRF service following joint replacement surgery</td>
<td>$20.6 m</td>
<td>1,833</td>
<td>CA</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Heart Failure and Shock</td>
<td>$7.9 m</td>
<td>695</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2.0 m</td>
<td>306</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$9.5 m</td>
<td>2190</td>
<td>FL</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Surgical Procedures in Wrong Setting</td>
<td>$17.1 m</td>
<td>1,610</td>
<td>NY</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Respiratory System Diagnosis with Ventilator Support</td>
<td>$9.6 m</td>
<td>577</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$4.1 m</td>
<td>265</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1.7 m</td>
<td>123</td>
<td>FL</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Extensive OR procedures Unrelated to Principal Diagnosis</td>
<td>$5.9 m</td>
<td>269</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3.5 m</td>
<td>254</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1.5 m</td>
<td>123</td>
<td>FL</td>
</tr>
</tbody>
</table>

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## 2007 CMS RAC Status Report Observations

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Description of Item or Service</th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Cases Overturned on Appeal</th>
<th>Location of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital</td>
<td>Colonoscopy</td>
<td>$2.9 m</td>
<td>5,194</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td>Speech Language Pathology Services</td>
<td>$1.4 m</td>
<td>3,205</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>Infusion Services</td>
<td>$1.3 m</td>
<td>9,556</td>
<td>CA</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Physical Therapy and Occupational Therapy</td>
<td>$1.9 m</td>
<td>1,914</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>Speech Language Pathology Services</td>
<td>$1.5 m</td>
<td>2,160</td>
<td>CA</td>
</tr>
<tr>
<td>Physician</td>
<td>Pharmaceutical Injections</td>
<td>$2.3 m</td>
<td>9,534</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>Duplicate Claims</td>
<td>$1.8 m</td>
<td>15,305</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>Venous Function Tests</td>
<td>$1.4 m</td>
<td>12,086</td>
<td>FL</td>
</tr>
<tr>
<td>Lab/Anesthesia</td>
<td>Infusion services during hospital inpatient stay</td>
<td>$2.3 m</td>
<td>5,888</td>
<td>CA</td>
</tr>
<tr>
<td>DME</td>
<td>Items during hospital inpatient stay or SNF stay</td>
<td>$1.5 m</td>
<td>12,569</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1.5 m</td>
<td>16,366</td>
<td>CA</td>
</tr>
</tbody>
</table>

Source: [CMS data](link)

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Next Steps: Assembling the Right Team

1. Proactive preparation & anticipation
   - Form multidisciplinary team for effective RAC response
     • HIM, Finance-Patient Accounts, Risk Management, Quality Assurance, Case Management, Physician Liaison and Legal Counsel
   - Identify facility RAC Liaison – primary point of contact
     • But have an understudy / backup
   - Identify resources needed – budget impact (internal & external)

Next Steps: Establish Processes

2. Prepare Information for Effective Review By Team
   - Log each Demand Letter / Request for Medical Record into Tracking System
   - Verify that the claim is open for RAC to review.
     • Do not assume RAC database is accurate
     • If you conclude line item on claim has already been reviewed, notify RAC, FI, QIO, etc.
   - Classify each demand by type of issue and $$ Impact
     • (e.g., Duplicate Payment, Beneficiary Service Not Covered, Not Medically Necessary, DRG recode, HCPCS Error, Units, etc.)
Next Steps: Establish Processes

3. Review Every Demand
   – Do not delegate key decisions to only 1 person
   – Team should meet often and regularly to review new demands/requests / status of prior demands.
   – Prioritize review of claims by time remaining to respond; $$ impact; and volume of claims with common issues.
     • Goal is to avoid any technical denials
   – If volume of requests / demands is determined to be excessively burdensome, formally request extension by RAC, notify CMS, and inform Association

4. Primary Responsibilities
   – Is RAC’s determination of overpayment correct?
     • Understand the specific rules / policies
       – Do not blindly accept RAC interpretation of rules/guidelines
       – Look to see if policy / rule has changed over time
   – If RAC is not following rules, notify Association / CMS ASAP with documentation
OIG Review of RAC “duplicate payment”

Daniel R. Levinson
Inspector General

October 2006
A-03-06-00004

SUMMARY OF FINDING

None of the 241 claims that the RAC initially identified were duplicate payments. Of the 241 claims, 12 claims included overpayments, totaling $44,746, for six beneficiary stays with 1-day admissions and subsequent same-day readmissions. The remaining 229 claims were routine claims and adjustment transactions that were paid correctly and did not involve duplicate payments.

Next Steps: Establish Processes

5. Repayments
   – When an overpayment occurred, determine and implement corrective action to avoid repeat
     – Ask for partial payment whenever possible
     – Determine if other payers will pay denied claim
   – Request waiver of timely filing deadlines for identified underpayments
Next Steps: Appeals Process

6. Team should review appeal documentation to ensure it is complete, accurate and convincing
   – Share successful strategies with peers
   – Tracking database
   – Standard templates for specific denial types
   – Identification of practices resulting in denials

7. Ensure timelines for medical record documentation requests are compliant
   – Create central repository for all communication between your facility and the RAC

Issues for Consideration

• Use the results of RAC to prospectively improve identified coding and documentation issues
• Uniform tracking on an industry basis is critical
• Identification of Underpayments is in your interest
• Establishing Criteria / Trigger Points for Appeals
• Interest Payments and Potential Differentials
• RAC Impact on Your Medical Staff
• Impact of MS-DRGs on future year RAC audits
• MAC implementation in your state
Selected Resources & Information

- Link to RAC CMS Home Page:
  http://www.cms.hhs.gov/RAC/
- Link to RAC Status Document:
A CALIFORNIA EXPERIENCE ON THE “RAC”

Overview, Mechanics and Tips
From the Rehabilitation Perspective

Topics

• The Inpatient Rehabilitation Facility (IRF)
• What is Reasonable and Necessary
• Medical Appropriateness vs. Medically Necessity
• The importance of medical record DOCUMENTATION
• Insure access to appropriate care for people with disabilities
Auditor under fire reaps big profits

Firm has been criticized for rejecting many hospital Medicare claims in state.

By David Whitney - Ber Washington Bureau
Published 12:00 am PDT Friday, August 3, 2007

PRG-Schultz International, the Atlanta auditing company under fire for its sweeping rejection of claims for California Medicare patients cared for by rehabilitation hospitals, announced soaring second-quarter profits Thursday.

PRG-Schultz was given a three-year contract to audit Medicare payments under a congressionally mandated pilot program that earns it a bounty of 25 percent to 30 percent for every dollar it recovers. The pilot program ends next year, but Congress is making the program national, and PRG-Schultz officials said the company hopes to pick up a multistate contract for the West.

Blum Capital Partners, a business venture of Richard Blum, the husband of Sen. Dianne Feinstein, D-Calif., is a major investor in the company and as a result of a restructuring last year, holds a seat on the auditing company’s board.

Audits sting hospitals, physicians

By KEVIN FREKING, Associated Press Writer/Sat Mar 1, 8:07 AM ET

In coming weeks, private audit companies will begin scouring mountains of medical records. Their mission: Determine if health care providers erred when billing Medicare and require them to return any overpayments to the federal government. The auditors will keep a tidy percentage for their services.

One of the hospitals targeted by the Recovery Audit Program was the Rehabilitation Institute at Santa Barbara, Calif. The center treated patients who needed extensive therapy because they suffered a stroke, brain injury or other serious injury. According to the institute’s CEO, the private auditor for California, PRG-Schultz International, reviewed medical records for about 314 patients. In all but a handful of cases, the contractor determined the patient failed to meet Medicare’s criteria for admission into an inpatient rehabilitation facility.

With a $2.9 million ICU to the government hanging over its head, the 50-year-old rehab hospital hatched its search for a partner or buyer. It decided that selling its assets to a local hospital was the best way to ensure its services to the Santa Barbara community would continue.

What we have here is bureaucrats and government contractors coming in and trying to second guess what doctors and nurses have done in a hospital setting,” said Dan May, vice president for policy at the American Hospital Association. “They’re playing Monday morning quarterback.”
The Appeals Process

- Recovery Audit Contractor (RAC) Denial
- Fiscal Intermediary (FI) Initial Determination
- FI Redetermination
- Qualified Independent Contractor (QIC) Reconsideration
- Administrative Law Judge (ALJ) Appeal
- Medicare Appeals Council (MAC) Appeal
- Federal District Court

Inpatient Rehabilitation Facility (IRF)

- In 1985, CMS (then HCFA) issued HCFA Ruling 85-2, “There are two basic requirements which must be met for inpatient hospital stays for rehabilitation care to be covered:
  1) The services must be *reasonable and necessary* (in terms of efficacy, duration, frequency and amount) for the treatment of the patients condition; and
  2) It must be *reasonable and necessary* to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis.
What is “reasonable and necessary”?

- Ruling 85-2 set forth 8 criteria, which, if satisfied, demonstrate that the patient meets the two “reasonable and necessary” requirements for inpatient rehabilitation.

The 8 Criteria

1) Close medical supervision by a physician with specialized training or experience in rehabilitation
2) 24 hour rehabilitation nursing
3) Relatively intense level of rehabilitation services (the “3-hour rule”)
4) Multi-disciplinary team approach to delivery of program
5) Coordinated program of care
6) Significant practical improvement
7) Realistic goals
8) Length of rehabilitation program
• **Medical Appropriateness**
  – Refers to the clinical judgment of a physician that a patient needs care, has potential to benefit and the most appropriate environment for the care to be delivered is the acute inpatient rehabilitation facility.

• **Medical Necessity**
  – Refers to the clinical judgment of a physician that a patient needs care, has potential to benefit and the most appropriate environment for the care to be delivered is the acute inpatient rehabilitation facility.

The 8 Criteria, if met, establish the medical necessity of acute inpatient rehabilitation.
The Preadmission Screen
A Prospective view

The “Monday Morning Quarterback”
A Retrospective view

PRG Schultz determined the claim did not meet medical necessity due to:

• Documentation did not support the need for an intense level of rehabilitation on an inpatient hospital basis
• Documentation failed to support the presence of a complicating medical problem or risk of change in medical status to support the need for frequent assessment and intervention of a physician
• Documentation did not support the need for close medical supervision by a physician with specialized training or experience in rehabilitation
• Documentation did not support the patient was a candidate for an intense level of rehabilitation on an inpatient hospital basis
Demonstrate the Documentation

• Close medical supervision by a physician with specialized training or experience in rehabilitation

Demonstrate the Documentation

• 24-hour rehabilitation nursing
Demonstrate the Documentation

• Relatively intense level of rehabilitation services
  – The “3-hour rule”

• Multi-disciplinary team approach to delivery of program
Demonstrate the Documentation

• Coordinated program of care

Demonstrate the Documentation

• Significant practical involvement
Demonstrate the Documentation

• Realistic goals

Demonstrate the Documentation

• Length of rehabilitation program
Determination of Medical Necessity for Admission to an Acute Rehabilitation Facility is the Responsibility of the Physician. This Medical Judgment is a Primary Function of the Practice of Medicine.

Tips for a Successful Appeal

- Organize the medical record
- Write in plain English
- Humanize the beneficiary
- Tell a story
- Request an “in person” hearing
- Bring the physician
- Review the medical record with the ALJ - page by page
Questions?