RACs / MIPs/ Third-Party Denials: Managing the Convergence of Compliance and Revenue Cycle Management Process Improvement.

HCCA’s Audio/Web Conference
September 3, 2008

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  - Staffing Analysis
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Section I: Understanding & Managing Denials

- Define:
  - Financial Impact
  - Organization Considerations
  - Data Capture and Reporting
  - Operational Considerations
  - Measuring Performance

Magnitude of the Problem

*Over the past decade, denials have tripled – and now potentially exceed, for some organizations, 10% of gross revenue*

*Source – Zimmerman & Associates*
Third-party Denials Defined

- **Direct Payer Feedback** – Full or Partial Denials
- **Underpayments** – Payments less than expected reimbursement amounts
- **Slow-Pay Accounts ("stalls")** – Pended or open claims.

Do You Know Your Denial Levels?

- You can estimate current denial levels through compiling and annualizing the following remittance data:
  - Compiling Electronic Remittance ("835") Payer Data
  - Sampling and analysis of 1 month "paper" remittance statements for the other major payers
Impact of Reducing Denials

• Denial Reduction is an annual BENEFIT – “It is truly the gift that keeps on giving”

• For example: Current Situation
  – Third-party Net Revenue: $105M
  – Current Denial Rate: 10%
  – “Year 0” Lost Net Revenue: $10.5M
  – Targeted Denial Rate Reduction: 40%

• Potential Increase in Annual Net Revenue (Cash Collections): **$4.2M**

Organization Considerations

1. Designated Leader
   – An effective Denial Management Program must have an “Organization Leader”. This individual must be responsible for defining ownership, accountability and communicating expectations and goals across the organization.

2. Organizational Commitment to Denial Management

3. Permanent Multi-disciplinary “Working” Committee
   – HIM
   – Access Management
   – Compliance / Internal Audit
   – PFS
   – Senior Management
   – Senior Medical Management
   – Contract Management

4. Organizational Defined Goals & Objectives
Operational Considerations

1. Database to Track Denials - Characteristics of the Database:
   - Single repository for denial reporting and tracking
   - Standardized usage definitions and “high level codes”
   - A “high” level (Roll-up code) crosswalk from HIPPA (CARC) Codes (Detailed on next two slides) and area/department that created the denial (Source Group code)
   - Flexible and scalable to support both current and future needs
   - A tool for issue identification / continuous quality improvement / and monitoring

Operational Considerations

2. Standardized “high” level denial codes to crosswalk the 250+ HIPPA (CARC) codes

   01 - No authorization
   02 - Level of Care Denial
   03 - Non-Covered Services
   04 - Pre-existing Condition
   05 - Rescission
   06 - Ineligible Date of Service
   07 - Usual & Customary Denial
   08 - Untimely Filing
   09 - Coding Denial (Error)
   10 - Coordination of Benefits
   11 - Duplicate Claim
   12 - Billing Denial (Error)
   13 - No Pre-Certification
   14 - No Referral
   15 - Lack of Notification
   16 - Partial Stay Denial
   17 - Partial Payment: Not authorized
   18 - Medical Necessity Denial
   19 - Authorization Number Not Valid
   20 - Member (Policyholder) Non-responsive to Information Request
   21 - Medical Center / Other Service Provider Non-responsive to Information Request
   22 - Medical Record Request / Other Clinical Request
   23 - Exhausted Benefits
   24 - Non-Contracted Service
   25 - Payment Review/Underpayment
   26 - Payment Review/Overpayment
   27 - Miscellaneous Administrative/Non-specific Voucher Item
   28 - Untimely Appeal
Operational Considerations

2. Standardized “high” level denial codes to crosswalk the 250+ HIPPA (CARC) codes

<table>
<thead>
<tr>
<th>CARC Code</th>
<th>Description</th>
<th>Denial Code (Roll-up)</th>
<th>Denial Source Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Applied to Deductible/Co-pay/LTR Days</td>
<td>30</td>
<td>Access Related</td>
</tr>
<tr>
<td>31</td>
<td>Capitated Member</td>
<td>31</td>
<td>Access Related</td>
</tr>
<tr>
<td>32</td>
<td>Stop Loss Deductible Not Met</td>
<td>32</td>
<td>Access Related</td>
</tr>
<tr>
<td>33</td>
<td>Contractual Discount / Reduction</td>
<td>33</td>
<td>Access Related</td>
</tr>
<tr>
<td>34</td>
<td>Charges in Excess of Fee Schedule</td>
<td>34</td>
<td>Access Related</td>
</tr>
<tr>
<td>35</td>
<td>Overturned Denial</td>
<td>35</td>
<td>Access Related</td>
</tr>
<tr>
<td>36</td>
<td>Outliers</td>
<td>36</td>
<td>Access Related</td>
</tr>
<tr>
<td>37</td>
<td>Primary Payer Amount</td>
<td>37</td>
<td>Access Related</td>
</tr>
<tr>
<td>38</td>
<td>Medical Education Adjustment</td>
<td>38</td>
<td>Access Related</td>
</tr>
<tr>
<td>39</td>
<td>Other Adjustment</td>
<td>39</td>
<td>Access Related</td>
</tr>
<tr>
<td>40</td>
<td>PIP</td>
<td>40</td>
<td>Access Related</td>
</tr>
<tr>
<td>41</td>
<td>Interest amount</td>
<td>41</td>
<td>Access Related</td>
</tr>
<tr>
<td>42</td>
<td>Payment Made to Patient</td>
<td>42</td>
<td>Access Related</td>
</tr>
<tr>
<td>43</td>
<td>Pre-determination</td>
<td>43</td>
<td>Access Related</td>
</tr>
<tr>
<td>44</td>
<td>Withholding</td>
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<td>Access Related</td>
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<tr>
<td>45</td>
<td>Patient Payment Option / Election Not in effect</td>
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<tr>
<td>46</td>
<td>Bundling Adjustment</td>
<td>46</td>
<td>Access Related</td>
</tr>
<tr>
<td>47</td>
<td>Claim submission Fee</td>
<td>47</td>
<td>Access Related</td>
</tr>
<tr>
<td>48</td>
<td>Pending / Deferred</td>
<td>48</td>
<td>Access Related</td>
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<tr>
<td>49</td>
<td>Medicaid Patient liability Amount</td>
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<tr>
<td>50</td>
<td>Refund</td>
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<tr>
<td>51</td>
<td>Covered Services</td>
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<td>Access Related</td>
</tr>
<tr>
<td>52</td>
<td>Physician (Provider) Eligibility / Proficiency</td>
<td>52</td>
<td>Access Related</td>
</tr>
<tr>
<td>53</td>
<td>Included in Care Furnished by Other Physician / Provider</td>
<td>53</td>
<td>Access Related</td>
</tr>
</tbody>
</table>

Sample HIPAA CODE
Crosswalks: Toll-up and Source Group Codes

DENIAL SOURCE GROUP
A = Access Related
B = Billing Related
I = Informational/Investigative
M = Medical record Related
O = Other / Unidentified
P = Payer Related
U = Utilization Review / Case Management Related
Minimum Database Components

- Patient Name / Account Number
- Admission / Discharge Date
- Hospital Service
- Admitting Physician
- Denial Reason (Code)
- Denial Amount
- Denied Days
- Remittance Date
- Payer Code/Financial Class
- Diagnosis (Discharge/Admit)
- Revenue Codes
- CPT Codes
- Patient Type

Tracking, Recovering, & Minimizing Denials – Technology is Essential
A Sample View of Denial Management Technology

Viewing Denials by Payer
Viewing Denials by Service Area

Viewing Detail Account Listing
Operational Considerations

1. Recovery Group
   - Primary focus on tracking and collecting “denied or underpaid” claims
   - Focused warehouse of payer specific knowledge
   - Bridge builder and liaison with other impacting revenue cycle areas
   - Provides an audit function to monitor department specific revenue cycle performance

2. Training and Education: Payer Requirements and Compliance Monitoring
Operational Considerations:

3. Process Management / Controls
   - Integrated workflows that support timely and accurate data collection
   - Quality reviews to ensure accuracy, quality, and completeness:
     • Scheduling and Registration Data
     • Coding
     • Documentation
     • Charge Entry
     • Information dispersal – Internally, externally, and customers
     • Billing / Billing Edits
     • Payer communication / updates / corrections / inquiries
   - Integrated reporting and communication within the totality of the revenue cycle

Operational Considerations:

4. Strong Appeals Apparatus and Process
   -- **Verbal Appeals**: Effective and often overlooked avenue for overturning the initial decision
   -- **First Level Appeals**: Timeliness and ensuring that the argument is specific to the issue/patient’s medical condition is essential. Site specific federal/state statutes as applicable
   -- **Second Level Appeals**: The argument should be related to errors in their thought process in denying the initial appeal – not solely a re-hashing of the arguments in the initial appeal. Include the potential financial impact on patient or guarantor
   -- **Litigation**: Always keep open as an option
Measuring Performance

You have been successful in the development of a “Denial Management Program” if you have achieved the following:

– Provided valid and reliable information concerning the volume and dollar value of denials by reason and payer – the information is formatted to support both recovery activities and process/quality improvement efforts

– A “team” is in place to promptly transform issues/deficiencies into corrective actions to prospectively continually reduce denial levels

– Integrated technical and corrective action training and compliance programs are in place

Measuring Performance

-- Denied claims can be isolated and tracked separately within the A/R Management System

-- Information is readily available for distribution across the continuum

-- Payer performance is tracked monthly for:
  – Denial Types / Denial Rate
  – Recovery Rates
  – Write-Offs

-- Information is shared across the total organization

-- Changes in payer denial patterns or requirements are constantly monitored and analyzed for the root cause(s)
Section II: Recovery Audit Contractor (RAC)

RAC – Background Information

- Medicare Modernization Act of 2003 directs CMS to utilize RAC's to identify and recoup Medicare overpayments and underpayments
- March 2005 CMS commenced a three year pilot demonstration project in:
  - California
  - Florida
  - New York
- Expanded to Massachusetts, South Carolina, and Arizona in 2007
- 2009 – Full roll-out in all states
- CMS plans have a permanent, nationwide RAC program by 2010
RAC Results -- As of July 2008

- Over (Improper) Payment -- $992.7 million
- Underpayments -- $37.8M

RAC Review Process – Types of Reviews:

- **Automatic Reviews**: Computerized analysis of claims and coding practices – an error example is where the provider billed excessive units of services for a non-timed procedure.
- **Complex Medical Review**: The RAC requests the medical record and the reviewers review the record and other supplied documentation. The provider has 45 days to comply with the request.
RAC Review Process – Decision and Appeal Process:

- Provider is notified of the RAC determination within 60 days
- “Demand Letters” are sent to the provider detailing the overpayment and the reason for the finding – includes the Providers “Right of Appeal”
- Appeal Options:
  - Rebuttal – must be filed within 15 days of the determination (Note: Not required for a first level appeal)
  - First level appeal -- must be filed within 120 days of the determination
  - Appeal to the Qualified Independent Contractor (QIC) -- must be filed within 180 days of the decision by the fiscal intermediary
  - Appeal to an Administrative Law Judge -- must be filed within 60 days of the decision by the QIC
  - Appeal to the qualified Medicare Appeals Counsel (MAC) -- must be filed within 60 days of the decision by the administrative law judge
  - Appeal to U.S. District Court -- must be filed within 60 days of the decision by the MAC

RAC Review Process – Deciding what to appeal:

- Criteria / issues to consider before you appeal a determination to ensure that, given the strict time constraints, resources are allocated to the determinations that have a higher probability of success:
  a) Cost: Benefit
  b) Resource requirements / availability of resources
  c) Likelihood of a positive outcome
  d) Implications of challenging or not challenging on your clinical practices
  e) Availability and quality of documentation
RAC Review Process – Components of a compelling appeal:

- Rebuttal of the specific reason that the reviewer determined that it did not meet Medicare’s medical necessity standards – Why in fact the services were medically necessary
- The Provider that ordered the services is trained in the Medicare medical necessity rules that govern those services – Physicians given their training are better equipped to make these complex determinations
- The RAC reviewer lacks the clinical background to evaluate the medical necessity of the services performed
- Services provided are consistent with the community standards where we practice
- Prior reviews / audits did not find these services failed to meet medical necessity standards

RAC Review Process – Pre-review preparedness:

1. Define and form a multidisciplinary team that would ensure a comprehensive approach to managing the RAC / RAC environment.
2. Define and create a methodology, data base, and process to “track” the RAC Audit Process, ensuring that it is readily available to all team members and that it contains all required data elements, accounts statuses, deadlines, open items, resolution/outcomes, and responsible party.
3. Define the optimum environment and processes for complying with Medical Record / Clinical Documentation requests.
4. Develop customized educational programs for Senior Management/Hospital Board, RAC Team, and staff member of affected areas.
5. Develop a proactive approach to conducting an internal audit on historical RAC target areas – and utilizing data mining queries identify potential areas of weakness and potential vulnerability – specifically related to CMS defined utilization thresholds and measures.
6. Develop and implement a corrective action plan based on findings from the internal review – which should be inclusive of:
   - Staff and provider education – inclusive of all revenue cycle management components
   - Policy / Procedure updates – specific to the deficient revenue cycle areas
   - Training on new policies and procedures
   - Compliance tools to monitor adherence with the new policies and procedures
   - Organization-wide reporting of RAC preparedness and current actions required
RAC Review Process – Physician Services / Group Practices:

- Physician services E & M coding have not been an initial focus of the RAC, <4% of claims reviewed -- but it is only a matter of time for this to be a target area.

**Recommendation:** Consider including E & M coding as a component of your pre-review internal audit.
MIP – Background Information

- Section 6034 of the federal Deficit Reduction Act (DRA) of 2005 created the Medicaid Integrity Program (MIP) to be implemented by CMS
- MIP's sole purpose is to identify, recover, and prevent overpayments resulting from fraud, waste, and abuse
- Commencing FY'09 funding for MIP's set at $75 million annually
- CMS is contracting with Medicaid Integrity Contractors (MIC's) to carry out the program review components
- MIC's will develop sophisticated data mining tools to review provider billing databases via utilizing fraud and abuse typologies – including matching Medicare and Medicaid to find patterns of fraud previously undetectable through the individual databases
- Providers will be targeted based on paid claims
- Findings will be referred to applicable federal and state agencies

Medicaid Integrity Program (MIP) – Impact on providers

- Increased reliance on methodologies to identify and correct billing errors, fraud and abuse is required
- Increasing frequency of sampling and reviews for early detection of potential problem areas
- Creating, internally or externally supported, sophisticated sampling techniques that are both statistically valid and conform to CMS’s methods is required
- The basis for the “loss calculation” will be the result of extrapolating the findings from a small number of claims – Providers will be required to undertake an in-depth review of the sampling and projection of damages methodologies
- Deficit Reduction Act additionally included two False Claims Act related provisions to promote “whistleblower” activities in Medicaid:
  - Section 6031 – Creates incentives if a State enacts a False Claims Act that mirrors that of federal law
  - Section 6032 – Any organization that receives or makes Medicaid payments of $5 million annually, must provide False Claims Act education to their employees
Questions & Answers