The Latest on Medicare RACs

This roundtable discussion is brought to you by the Regulation, Accreditation, and Payment (RAP) and is sponsored by Horne LLP.

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Latest RAC Statistics

- The investment in RACs will rise from $259 million in 2011 to $500 million in 2012, a sign they will recoup more money from providers.
- The most recent update, which provides information on the time period July 1, 2011 to September 30, 2011, identifies $277.1 million in overpayments and $76.6 million in underpayments, for a total of $353.7 million in improper payments.
- These numbers are up from the previous quarter, for which CMS reported $233.4 million in overpayments and $55.9 million in underpayments for a total correction amount of $289.3 million.
Latest RAC Statistics (cont’d)

- For each quarter CMS has issued these reports, the total correction amount numbers have raised dramatically:
  - October 2009 – September 2010: $92.3 million
  - October 2010 - December 2010: $94.3 million
  - January 2011 - March 2011: $208.9 million
  - March 2011- June 2011: $289.3 million
  - July 2011 – September 2011: $353.7 million
Latest RAC Statistics (cont’d)

- CMS described the categories of errors that led to the most significant recoveries:
  - **RAC Region A**: Incorrect code ($3,171,808); unbundling ($563,485); noncovered, nonallowed & other services ($382,015); medically unnecessary items or services ($276,736) and incorrect discharge status ($157,192).
  - **RAC Region B**: Incorrect number of units ($9,606,678); incorrect code ($4,159,492); incorrect Medicare service provider billed ($398,050); unbundling ($90,742); and incorrect discharge status code ($60,770).
  - **RAC Region C**: Incorrect code ($18,164,294); incorrect number of units ($3,219,533); unbundling ($2,787,660); noncovered, nonallowed, other services ($44,024); and multiple error code values within claim ($5,567).
  - **RAC Region D**: Unbundling ($11,835,149); incorrect code ($5,598,794); noncovered, nonallowed, other services ($2,764,816); incorrect number of units ($2,366,098); and incorrect discharge status ($1,772,106).

Reference: AIS; RACs: Proven Tips and Tactics to Reduce Your Audit Risks and Appeal Payment Denials
Contractor Report Cards

The four RACs were rated on the quality and outcomes of their audits as assessed by CMS’s validation contractor.

- *Diversified Consulting Services (Region A)*: 98.6
- *CGI (Region B)*: 99.2
- *Connolly (Region C)*
- *HealthDataInsights (Region D)*: 99.4
New RAC Statement of Work

- The new statement of work spells out RACs job duties through February 2014.
- SOW spells out the provider types who are allowed to be audited for improper payments.
- RACs may focus less on hospitals and more on other provider types and look harder for underpayments.
- RACs are required to develop procedures to minimize the burden on providers when identifying over-payments.
- CMS formalized a new type of RAC audit, the semi-automated review.
New RAC Statement of Work (cont’d)

- RACs won’t get contingency fees for their overpayment determinations unless they comply with CMS’s deadline for completing a review.
- CMS added contractors to the RAC data warehouse.
- CMS is now calling RACs the “recovery auditors.”
- The possibility of rebilling MS-DRG lack of medical necessity denials as outpatient services seems to exist.
RAC Letters are Shifted to MACs

- As of January 2012, MACs have taken over the job of informing providers when RACs have concluded that certain overpayments exist.
- CMS representatives indicated that this change will eliminate providers getting late or untimely demand letters because the demand letters will automatically be issued after adjustment by the MAC.
- The RAC to MAC change won’t affect the discussion period and the providers will still get reasons for denial from the recovery auditor.
Sending Records Electronically

- When providers get the request letter from a contractor, they have the choice of mailing the paper records, mailing a CD or faxing the records.
- CMS made this move because it realizes how arduous, time-consuming and expensive it is for providers to submit documentation to Medicare auditors for claims review the old-fashioned way.
- The solution is Electronic Submission of Medical Documentation (esMD).
- The program will roll out in two stages.
Sending Records Electronically (cont’d)

- **Phase I: As of September 2011; will still involve paper**
  - The contractors will still send a letter through the mail to the provider, but the provider will be able to submit the requested documents electronically.

- **Phase II: Maybe operational by October 2012**
  - Contractors will send their documentation requests electronically to providers and providers will submit electronically.

- Participation in esMD will not be mandatory.

- The esMD program will be linked to the Nationwide Health Information Network.
Sending Records Electronically (cont’d)

- CMS hopes eventually that esMD users will be able to view outbound documentation requests, the status of claims and appeals information, administrative transactions (e.g., eligibility look-up), claims submission, and refund submission.

- A big benefit for Durable medical equipment (DME) suppliers who need to communicate with physician offices.
Semi-automated Review

- An additional process for identifying a claims overpayment has been added to the SOW called the “semi-automated review”.
- The review will entail an automated review using claims data and potential human review of a medical record or other documentation.
- The “semi-automated review” will be used when a clear CMS policy does not exist but the items and services that are billed would be clinically unlikely or inconsistent with evidence-based medical literature.
Semi-automated Review (cont’d)

- The process begins with an automated review of the claim to identify claims with items or services billed that would be clinically unlikely or inconsistent with evidence-based medical literature.

- The Recovery Auditor would then send a notification letter to the provider requesting additional documentation to support the claim within 45 days. If the documentation does not support the claim then the claim will be adjusted and a demand letter will be sent to the provider. If the documentation does support the claim the provider will be notified that the review has been closed.
RAC Target Areas

- **Diversified Collection Services (Region A):**
  - Ventilator Support of 96+ hours
  - Renal and urinary tract disorders (medical necessity)

- **CGI, Inc. (Region B):**
  - Extensive Operating Room Procedure Unrelated to Principal Diagnosis
  - Surgical cardiovascular procedures (medical necessity)
RAC Target Areas (cont’d)

- **Connolly, Inc. (Region C):**
  - DMEPOS Provided During an Inpatient Stay
  - Acute inpatient admission neurological disorders (medical necessity)

- **HealthDataInsights (Region D)**
  - DMEPOS Provided During an Inpatient Stay
  - Minor surgery and other treatment billed as inpatient (medical necessity)
Overall Target Areas

- Transfers to Post-Acute Care (PACT) rule
- DRG 79 – Respiratory infection and inflammation age greater than 17 with complications and/or comorbidities
- DRG 87 – Pulmonary edema and respiratory failure
- DRG 416 – Septicemia in individuals older than 17
- Ambulance services separately payable during an inpatient hospital stay (Inpatient hospitals, ambulance providers)
Overall Target Areas (cont’d)

- Billing for Arformoterol (Brovana®) (J7605) and Formoteral fumarate (Perforomist®) (Q4099) (Durable medical equipment suppliers)
- Diseases and disorders of the circulatory system (Inpatient hospitals)
- Lower limb suction valve prosthesis (Durable medical equipment suppliers)
- Minor surgery and other treatment billed as inpatient stay (Inpatient hospital)
Overall Target Areas (cont’d)

- Respiratory system DRG 076, MS-DRGs 166, 167, 177, 178, and 179 (Inpatient hospitals)
- Chronic obstructive pulmonary disease (COPD) MS-DRGs 190, 191, and 192 (Medical necessity review and MS-DRG validation) — Inappropriate and insufficient documentation (Inpatient setting)
- Overutilization of positive airway pressure (PAP) and respiratory assist device (RAD) accessories — Improperly billed quantities (DMEPOS suppliers)
Overall Target Areas (cont’d)

- Modifier -25, *Separately Identifiable E&M Service on the Same Day as a Minor Procedure*

- Place of Service Codes
  - POS code 11 (offices),
    - CPT code 99291; Critical care first hour
    - CPT code 85097; Bone marrow interpretation
    - CPT code 90801; Psychiatric diagnostic interview examination
  - POS code 21 (hospital inpatient departments), and
  - POS code 22 (hospital outpatient departments)
Focus on Medical Necessity

- RACs have been focusing on the correct setting of care but also on whether a procedure was necessary at all.
- Cardiac Procedures – stents, pacemakers and automatic implantable cardiac defibrillators (AICDs) are high on this radar.
- Kidney Injury and Urinary Surgery are a focus.
- According to the American Hospital Association (AHA) August 2011 report, the percentage of hospitals experiencing RAC medical necessity overpayment determinations rose from 84% to 93% between the first and second quarters of 2011.
Focus on Medical Necessity (cont’d)

- The bulk of RAC admission-necessity denials stem from short stays (one or two days).
  - RACs now are reviewing short stays for medical DRGs, such as syncope, transient ischemic attack and chest pain, and surgical DRGs, including urological and gynecological procedures.
- Hospitals tend to appeal overpayment determinations when they believe they have complied with Medicare medical-necessity guidelines.
- The majority of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary.
OIG’s Medicare Compliance Reviews

- Outpatient claims billed during DRG payment window
- Inpatient manufacturer credits for replacement for medical devices
- Outpatient manufacturer credits for replacement of medical devices
- Post-acute transfers to SNF/HHA/another acute care/non-acute inpatient facility
- SNF/HHA consolidated billing – outpatient services
- Outpatient claims billed with modifier -59
- Inpatient claims paid greater than charges
OIG’s Medicare Compliance Reviews (cont’d)

- Inpatient claims paid greater than charges
- Inpatient payments greater than $150,000
- Outpatient payments greater than $25,000
- Payments for hemophilia services
- One-day stays at acute care
- Major complication/comorbidity and complication/comorbidity
- Payments for septicemia services
- Payments for inpatient same-day discharges and readmissions, and
- Payments for outpatient surgeries billed with units greater than one
Strategies for Success

- It is important to keep an eye on the material posted by MACs, ZPICs, OIG, and CERT because they produce reports for CMS that are good sources of compliance monitoring.

- Physicians must document and explain how patient’s meet LCD and NCD coverage guidelines.

- Hospitals and clinics should review their current query policy, form and process.

- According to CMS, MS-DRGs should not be coded until the providers have finalized their documentation.

  □ MLN Matters SE 1121
Strategies for Success (cont’d)

- If you identify an error in audit, make sure it gets rectified.
- Facilities should update their compliance programs in response to new enforcement activities.
- One of the best defenses is a strong case management function and utilization review committee.
- Hospitals should drill down into billing data from CMS’s Program to Evaluate Payment Patterns Electronic Report (PEPPER).
  - The admission necessity target areas include syncope, two-day stays for cardiac arrhythmia and 30 day readmissions.
  - The coding target areas include septicemia, ventilator support and unrelated operating room procedures.
Physician Documentation

- To ensure proper documentation, physicians should include a clear plan of care and impression in the history and physical.
- Notes for procedures should always address any risk linked to medical history.
- Continued-stay reviews with a recommendation for inpatient status should always include current progress notes or orders to evidence the basis for continued acute care following stabilization.
Physician Documentation (cont’d)

- The CMS Medicare Benefit Policy Manual highlights five key pieces of documentation for Medicare cases and determining medical necessity of inpatient status. These points include:
  - Medical history;
  - Current medical needs;
  - Severity of signs and symptoms;
  - Facilities available for adequate care; and
  - Predictability of an adverse outcome.
    - Risk assessment
    - Prior Response
    - Concern for a serious outcome if the patient is not closely monitored on admission
    - Notation that the standard of care is being met
Collection of Documentation

- Every facility should have a RAC “gatekeeper.”
- Submit all required documentation during first two stages of Medicare appeals (but try and get it right the first time).
- Review the record prior to sending information.
- Copy all information submitted to the carrier.
Practical Tips for Appeals

- **Get the treating physician involved** - he or she has examined the patient and is most familiar with patient’s condition absent substantial evidence to the contrary and the physician’s judgment should receive deference.

- **Waiver of liability** - payment may be made if provider or supplier did not know and could not have reasonably known payment would not be made. Generally applies to medical necessity and provider should support with carrier or FI communications.

- **Provider without fault** - exercised reasonable care in billing and accepting payment, complied with pertinent regulations, disclosed material facts, etc.
Practical Tips for Appeals (cont’d)

- Develop standard templates for specific denials (E & M, medical necessity).
- Include cover letter itemizing all information included.
- Rely on other source documents such as AMA CPT Assistance and ICD-9-CM: AHA Coding Clinic.
- Work with clinicians and billing experts to develop the appeal.
  - Procedural-Did auditor follow rules?
  - Substantive-Was the service medically necessary
Practical Tips for Appeals (cont’d)

- Dealing with Extrapolation
  - Scrutinize the auditor’s documentation of its random sampling.
  - Verify that the sample size was sufficient.
  - Verify the calculations.
  - Determine if the sample was randomly selected.
  - Compare the RAC’s process to the Medicare Program Integrity Manual guidelines on the subject.
Appeal Considerations

- Reviewer used the wrong Standards
- Reviewer applied the standards incorrectly
- Is there clear guidance from CMS or the payer?
- Sufficiency of clinical documentation
- Cost versus benefit of appeal
- Availability of clinical support and input
- Use the right people from the company
- Know the auditor’s timetables
- Get specifics of what the auditors reviewed (i.e., physician offices records only, etc.)
Hospitals Reporting RAC Process Issues

- Long lag (greater 30 days) between date on review results letter and receipt of demand letter
- Problems reconciling pending and actual recoupment due to insufficient or confusing information on the RA
- RAC not meeting 60 day deadline to make a determination on a claim
- Receiving a demand letter announcing a RAC denial and pending recoupment after the denial has been reported on the RA.
- Not receiving a demand letter informing the hospital of a RAC denial
- Problems with RA RAC code N432
- Demand letters lack a detailed explanation of the RAC’s rationale for denying the claim

Reference: RAC Trac
Recovery Audit Prepayment Review Demo Project

- CMS has announced a pilot program to let RACs conduct prepayment reviews.
- Started in January 2012.
- RACs will review select claims to determine whether the provider complied with all Medicare payment rules before Medicare writes the check.
- Many providers have suggested that prepayment audits are a strain because they suspend payments for services unless the claims are given the OK.
- The aim is to avoid the traditional “pay and chase” method.
Prepayment Review Demo Project

- The prepayment RAC demonstration will take place in 11 states:

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Prepayment Review Demo Project (cont’d)

- CMS has not yet finalized the list of services subject to prepayment review nor has the agency offered insight into the amount of resources committed to prepayment reviews by RACs, such as the percent of cases evaluated, complexity of the reviews, or even the time spent conducting prepayment reviews versus the current practice of post payment review.
QUESTIONS