Healthcare on the RAC

(Recovery Audit Contractor Program that is…)

Presented by:

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Learning Objectives

- Why the Recovery Audit Program (RAC) was created
- Impact of RACs on Providers
- Understanding RAC Targets and Provider Preparation

BACKGROUND – Why RAC's?

- Medicare Fee-For-Service (FFS) program consists of a number of payment systems, with a network of contractors that process >1.2 billion claims annually; submitted by hospitals, physicians, SNF, labs, ambulance companies, and DME suppliers

- These contractors are called Medicare Administrative Contractors (MACs)

BACKGROUND – Why RAC's?

Provider confusion existed about the roles of various Medicare contractors involved in detecting improper payments…

Improper Payment Function	Contractor Performing Function
Preventing future improper payments through pre-pay review and provider education	Medicare Administrative Contractors (MACs) In NJ, Highmark Medicare Services
Detecting past improper payments	RACs In NJ, Diversified Collection Services (DCS)
Measuring improper payments	CERT
Performing higher-weighted DRG reviews and expedited coverage reviews	QIOs

BACKGROUND – Why RAC's?

- Medicare Administrative Contractors are responsible for:
  - **Processing claims**
    - 1.2 billion claims / year
    - 4.5 million claims / day
    - 574,000 claims / hour
    - 9,579 claims / minute
  - **Making payments to providers** in accordance with Medicare Regulations
  - **Educating providers** on how to submit accurately coded claims, that meet Medicare's Medical Necessity Guidelines

BACKGROUND – Why RAC's?

- Improper Medicare FFS Payments Report* estimates 3.9% of Medicare dollars did not comply with one or more Medicare coverage, coding, billing, or payment rules. This equals $10.8 BILLION, the third largest payment error
  - Medicaid is the first = $12.9 Billion in erroneous payments
  - Income Tax is second = $11.4 Billion in erroneous payments

* www.cms.hhs.gov/CERT

BACKGROUND – Why RAC's?

- RAC Legislation…IT'S THE LAW!
  - Medicare Modernization Act 306 of 2003
    - Directed DHHS to conduct demonstration projects to show use of RAC's in identifying improper payment errors
    - Section 302 of the Tax Relief and Health Care Act of 2006, required Congress to make the RAC program permanent and nationwide by January 1, 2010
  - RACS are paid by contingency fee:

RAC Program Mission

- **To detect and correct past improper payments**
- **To implement actions that will prevent future improper payments**
  - *Providers can avoid submitting claims that don't comply with Medicare rules*
  - *CMS can lower it's error rate (currently 3.9%)*
  - *Taxpayers and beneficiaries are protected*

RAC Demonstration Program

- The RACs succeeded in correcting over *$1.03 billion of Medicare improper payments
  - *96% were overpayments collected from providers*
  - *4% were underpayments returned to providers*

** includes payment errors corrected and prevented.*

RAC Demonstration Program

Overpayments by type of Error

Medical Necessity	$391.3 mil (40%)
Incorrect Coding	$331.8 mil (35%)
Documentation	$74.3 mil (8%)
Other	$160.2 mil (17%)

Getting Ready for the RAC's

- Pull together a RAC-Team – **WHO?**
  - Flow Chart – **Who is responsible for What?** From the date the letter is received through the entire appeals process
  - Identify who will receive the RAC requests
  - Who will assemble the record, per the request? **Who will ensure a timely response? To the initial request and all levels of appeal?**
  - Who will review the record prior to sending? **To ensure completeness**
  - Implement a system to track RAC requests and determinations
    - Track how much $ is at risk
    - Track how much $ is actually recouped
  - Develop a strategy relating to appeals – what cases will be appealed?

- Conduct Pre-RAC Data Quality Reviews
  - Audit claims subject to automated reviews
  - Audit claims subject to complex reviews

Getting Ready for the RAC's

- **Automated Review** – Data Mining from Claims Data
  - Not Medically Necessary – Local Coverage Determinations
  - Excessive Units – Inappropriate # Units Billed (drugs, transfusions)
  - Medically Unlikely Edits – MUE's
  - http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp

- **Complex Review** – Medical Record / Chart Requested
  - Observation – Review Physician Orders / Time In Observation
  - Chest Pain, COPD, Congestive Heart Failure, Circulatory Disorders, Heart Failure and Shock, UTIs, Wound Debridement, Sepsis
  - Utilization Management Issues

Our RAC - Diversified Collection Services
Recovery Audit Contractor: Region A

Send all correspondence to:
DCS Healthcare Services
Customer Service
2815 Southwest Blvd
San Antonio, TX 76904

DCSRAC@dcswins.com

Toll Free: 1 866 201 0580
Hours: 8:00am – 4:30pm EST

Outreach Dept: DiAnna Harrison-Jackson dharrison@dcswins.com

Diversified Collection Services
Recovery Audit Contractor: Region A

- Diversified Collection Services: http://www.dcsrac.com

RAC Request for Provider Contact Information

- Complete form on-line with your hospital / provider contact information
  - Review Results Letters
  - Demand Letters
  - Medical Record Requests

- Form can be located: http://www.dcsrac.com/racrequest.html

Provider Contact Information Form

RAC Request for Provider Contact Information

Diversified Collection Services (DCS) is the Recovery Audit Contractor (RAC) for Region A. Please provide your contact information for both Review Results Letters/Demand Letters and Medical Record Requests below. If you represent **multiple facilities/providers**, please complete this form for each facility/provider.

If you would like to fill out a **spreadsheet** instead of an online submission form, please fill out the spreadsheet linked below and email the completed spreadsheet to our RAC Customer Service Liaison.


Region A Provider Contact Information Spreadsheet.xls

* Please indicate your state AL

* Provider Name

* NPI #

* Hospital/Physician Group Name

Medicare Group NPI #

* Tax Identification #

Does your facility/office bill under any other NPIs? ☐ Yes ☐ No
If you checked yes, please fill out a form for each NPI.

Contact for Review Results Letters/Demand Letters

* Contact Person

* Telephone # (no dashes)

Title

Fax # (no dashes)

RAC News & Updates
Medical Records Request Limits

- Physicians
  - Solo Practitioner: 10 medical records per 45 days
  - Partnership of 2-5 Individuals: 20 medical records per 45 days
  - Group of 6-15 individuals: 30 medical records per 45 days
  - Large Group 16+ individuals: 50 medical records per 45 days
- Other Part B Providers (DME / Lab)
  - 1% of average monthly Medicare services per 45 days

RAC News & Updates – Q & A's

- **Q.** What types of claims may RACs identify and review?

- **A.** A RAC may attempt to identify improper payments on claims that are paid by carriers, FIs, MACs and other primary claims processing contractors in its jurisdiction.

- All Medicare fee-for-service providers including hospital inpatient and outpatient, long term care hospitals, inpatient psych, inpatient rehab, SNF, home health. Hospice, physician services, and DME suppliers are subject to RAC review

RAC News & Updates – Q & A's

- Before a RAC reopens a claim that is more than one year past the date of initial determination, it must have "good cause"

- The "good cause" standard for re-openings is defined as new evidence that was not available or known at the time a payment or appeals decision was made, or evidence that clearly shows the payment or appeals decision involved an obvious error or fraud

RAC News & Updates – Q & A's

- **Q.** What types of claims are RACs **NOT** permitted to review?
- **A.**
  - Services provided other than Medicare fee-for-service
  - Cost report settlement process
  - Claims older than 3 years
  - Claims paid earlier than 10-1-2007
  - Claims where beneficiary is liable for the overpayment (signed ABN)
  - Claims that are randomly selected or because they are high dollar claims
  - Claims involved in a Medicare demonstration
  - Prepayment Review
    - RAC can only review Medicare payments using the post payment review process
  - Claims that already have been reviewed
    - Claims previously reviewed by any contractor for any reason are off-limits to the RACs
    - RAC review **does not** preclude later fraud investigation (by anyone – ZPICs, OIG)

RAC News & Updates – Q & A's

- **Q.** How long does a provider have to submit a requested medical record?
- **A.** RAC must receive a requested medical record from a provider within 45 calendar days of the **date of the medical record request letter.** CMS has added an additional 10 days (5 for the RAC and 5 for the provider) to allow for US mail delivery time
- Note: the RAC is required to initiate one additional contact with the provider prior to denying the claim for failure to submit documentation

RAC News & Updates – Q & A's

- **Q.** Is the provider also responsible for returning the amount collected from the patient (co-insurance / deductible) or the secondary payer when an inappropriate overpayment is identified?

- **A.** Yes

RAC News & Updates – Q & A's

- **Q.** How will RACs communicate the results of an automated review?
- **A.** In the case of an automated review that results in an overpayment, the provider will receive a demand letter. Letter may contain a list of claims denied for the same reason. Letter will contain:
  - Amount of denial
  - Method for calculating the denial
  - Reason the original payment was incorrect
  - Regulatory and statutory basis for the denial
  - Providers option to submit a rebuttal statement (discussion period)
  - Providers appeals rights
  - Recoupment, payment and interest options and timeframes

RAC News & Updates – Complex Reviews

- RAC is permitted to obtain copies of medical records by going on-site to the providers location
  - Providers may refuse to allow a RAC access to their facilities
  - RAC then is prohibited from making an overpayment determination based upon lack of access
  - RAC has to request copies of the records in writing
- Records may be submitted via scanned images on CD or DVD
  - Must meet the requirements of the RAC
  - Requirements are still in development
- Rate for medical record copying is $0.12 per page (paid monthly and within 45 days of receiving the record – only Acute and SNF)

RAC NEWS & UPDATES
INITIAL FOCUS OF RACs – REGION C & REGION D

- Blood Transfusions – Excessive Units
  - CPT codes 36430, 36440, 36450, and 36455 should be billed as '1' per session, regardless of the number of units transfused on that date of service
- Untimed Codes – Excessive Units
  - Bill units of '1' , per date of service, for codes where the procedure is not defined by a specific time frame
  - For example, Speech Therapy, PT, OT
- IV Hydration Therapy – Excessive Units
  - When billing 90760 the maximum # of units = 1, per patient, per date of service
  - CMS Pub 100-04, Chapter 12

Getting Ready for the RAC's (Hospital Response)

- Pull together a RAC-Team – **WHO?**
  - Flow Chart – **Who is responsible for What?** From the date the letter is received through the entire appeals process
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Getting Ready for the RAC's (Physician Response)

- Maintain an active compliance program – appoint a Compliance Officer / Manager
- Self or Outside Audit
- Monitor the RAC website on a daily / weekly basis to identify new issues
- Educate staff and assign responsibility:
- Develop a response protocol and log all transaction: Time frames to deliver charts and to appeal
- Make sure documentation is clear and complete for all services including signatures, dates and credentials

Getting Ready for the RAC's (Physician Response)

- Medical Record Requests:
  - Who opens mail?
  - Who copies or scans charts and do they know what to copy - **do you have a reliable Copy Service**??
  - Are charts from 2007 on site?
  - Add cover letter to include any additional information to justify bill
  - Send all correspondence through tracked mail (< 45 days!)
  - Assure dates of documentation provided address RACs request
  - Be sure patient identifiers are on all pages
  - Keep track of what you send and when

Need Help or Have Questions?

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