# THE ISSUES

## CMS Provides More Explanation on RAC Review Process


More than 1,000 participants phoned in to the April 14 open door conference call sponsored by the Centers for Medicare & Medicaid Services (CMS). The topic: recovery audit contractors (RACs). According to CMS, there will be two types of reviews: automated reviews and complex reviews. Automated reviews will use data searches to identify misalignments in coding claims and will likely generate large volumes of re-payment requests in an automated format. These automated reviews may also then generate the complex review, in which the RAC identifies a claim issue and sends a written request for medical records. The provider has 45 days to reply and then the RAC has 60 days to send in the results. With regard to the specifics of RAC requests to providers:

- RACs can look backwards no more than three years from a period that begins Oct. 1, 2007.
- RACs cannot accept records electronically (via EMR). They can only accept images of medical records on CDs or paper.
- There is a limit on the number of records RACs can request: Solo practice, 10 records; 2-5 docs, 20 records; 6-15 docs, 30 records; and 16+ docs, 50 records.

Medicare providers in some parts of the country will begin receiving records requests from RACs in late June or July as the full post-payment review program begins rolling out nationwide, as reported in the June 1, 2009, *BNA Health Care Daily Report*.

For more on RACs, see "Ramp Up RAC Readiness!" on pages 11-13 or go online to: *www.cms.hhs.gov/rac.*

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## The Debates Continue on Comparative Effectiveness

At a May 13 public "listening session" of a new federal council on comparative effectiveness research, representatives of the medical community emphasized that federally funded research should consider effectiveness of healthcare treatments rather than costs. The 15-member Federal Coordinating Council for Comparative Effectiveness was expected to issue a final report June 30 on how to use $400 million in comparative effectiveness funding authorized by the American Recovery and Reinvestment Act of 2009.

In other news, the Deloitte Center for Health Solutions released a study on May 19 that profiled the

comparative effectiveness systems of other countries. It found that while using those same systems in the United States may not be viable, comparative effectiveness does have the potential to improve care and reduce healthcare costs for Americans—*if* implemented correctly.

The study examined three clinical examples of comparative effectiveness studies across national programs in the United Kingdom, Germany, Australia, and Canada:

1. Diagnostic screening detection in colon cancer
2. The use of statins for treatment of elevated cholesterol
3. A surgical treatment for benign prostatic hyperplasia.

According to the study, the examples were used to "demonstrate the complexities of conducting and reporting

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comparative effectiveness research. The examples also depict how data from comparative effectiveness studies is used to inform health policy decisions, including financial benefit decisions."

The full report is available at: *www.deloitte.com/us/comparativeeffectivenessreport*.

## CMS Will Share Data with Hospitals on New Imaging Efficiency Measures

CMS will share data on new imaging efficiency measures with hospitals later in 2009, prior to their use for 2010 payment determination, according to the May 26, 2009, *BNA Health Care Daily Report.* The hospital-specific reports will contain data derived from imaging fee-for-service claims, and it will be up to each hospital to verify the data, according to Mark Zezza, with the Lewin Group, who spoke during a CMS Special Open Door Forum. The contractor is working on the measures along with its subcontractors—National Imaging Associates (a radiology benefits manager) and consulting firm Dobson & DaVanzo & Associates.

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As reported by *BNA Health Care Daily*, Zezza said that hospitals will have a chance to validate the claims data—based on what the hospital had been paid for the activities in four areas—during a "dry run" before the end of the year.

Under the final Medicare hospital outpatient rule for 2009, published in November 2008, CMS expanded its quality requirements by adding four imaging efficiency measures that hospital outpatient departments must report in 2009. The four are part of the 11 reportable measures required to receive the full inflation update in 2010. The four imaging measures are:

- Estimating the percentage of beneficiaries who had a magnetic resonance imaging of the lumbar spine with a diagnosis of low back pain without claims-based evidence of antecedent conservative therapy
- Calculating the percentage of beneficiaries with mammography screening studies that are followed by another study

- Calculating the percentage of abdomen computed tomography (CT) studies performed with and without contrast
- Calculating the percentage of thorax studies that are performed with and without contrast.

In the rule, CMS said that the four measures are based on clinical evidence that show they promote efficient and high-quality patient care.

As reported in the *BNA Health Care Daily*, Thomas G. Dehn, with National Imaging Associates, said that the four measures were developed after observation of practice patterns that suggested inefficient use.

Hospitals' 2010 Outpatient Prospective Payment System (OPPS) payment rate update could be lowered by 2 percent if they do not successfully report on the measures in 2009. However, CMS officials said that for 2010 there will be no "value judgment" on a hospital's statistics and that they are used to judge reporting, not performance.

But Zezza noted that the data could offer hospitals insight and raise questions about efficiencies.

Some providers have objected to the measures, saying they were "not based on medical evidence" and did not pass a National Quality Forum review. CMS officials said that two of the four measures have been endorsed by NQF and that the others will be submitted for endorsement.

## CMS Says No to Medicare Reimbursement for Virtual Colonoscopy


In a memo posted on its website May 5, the agency stated, "We have determined that there is insufficient evidence on the test characteristics and performance of screening CT colonography in Medicare-aged individuals, and that the evidence is not sufficient to conclude that screening CT colonography improves health benefits for asymptomatic, average-risk Medicare beneficiaries." Many in the oncology community were unhappy with the decision.

As reported on Forbes.com, supporters of the procedure weren't pleased by the move. Dr. J. Leonard Lichtenfeld, deputy chief medical officer for the American Cancer Society, believes that a less-invasive method such as virtual colonoscopy might encourage more Americans to get screened for colon cancer, the country's second-leading cancer killer.

For more on CT colonography, see Dr. Abraham Dachman's article, "Colorectal Cancer Detection: The Role of CT Colonography" in a supplement to the May/June 2005 *Oncology Issues.* The special supplement, "Innovations in Imaging," is available online at: *www.accc-cancer.org.*

# Ramp Up RAC Readiness!

by Cindy C. Parman, CPC, CPC-H, RCC


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While healthcare organizations are focusing on implementing plans to survive the current economic crisis, the Centers for Medicare & Medicaid Services (CMS) is also working on its bottom line by expanding its Recovery Audit Contractor (RAC) program. Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directed the Department of Health and Human Services to conduct a three-year demonstration program using RACs to detect and correct improper payments in the Medicare fee-for-service program. The demonstration program was designed to determine whether using RACs would be a cost-effective means of adding resources to ensure providers and suppliers receive correct payments and, therefore, protect the Medicare Trust Fund by fighting fraud, waste, and abuse.

The RAC demonstration program, which was conducted in New York, Massachusetts, Florida, South Carolina, Arizona, and California, ended on March 27, 2008. As a result of the demonstration program, more than $900 million in overpayments was returned to the Medicare Trust Fund between 2005 and 2008, and nearly $38 million in underpayments was paid to healthcare providers.

The Tax Relief and Health Care Act of 2006 required that a permanent national RAC program be in place by January 1, 2010. The goal of the RAC program is to reduce improper payments to Medicare through:

- Efficient detection and collection of overpayments
- The identification of underpayments
- The implementation of actions that will prevent future improper payments.

The House Committee on Ways and Means estimates that the RAC initiative could save Medicare as much as $10 billion over five years when the program is expanded nationwide.

Overpayments occur when healthcare providers submit claims that do not meet Medicare's coding or medical necessity policies. At the same time, underpayments occur when healthcare providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed. Healthcare providers that might be reviewed under the RAC program include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers, and any other provider or supplier that bills Medicare Parts A and B.

## Who Are the RACs?

The Recovery Audit Contractors are independent medical collection agencies that are paid on a 9 percent to 12 percent contingency to detect both overpayments and underpayments. Under the contract, by 2010 there will be four RACs that can subcontract to supplement their efforts. The RAC jurisdictions match the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) jurisdictions:

- Region A: Diversified Collection Services, Inc. (DCS)
- Region B: CGI Technologies and Solutions, Inc. (CGI)
- Region C: Connolly Consulting, Inc. (Connolly)
- Region D: HealthDataInsights, Inc. (HDI)

To date, subcontractors include: PRG-Schultz, Inc. (Regions A, B, and D) and Viant Payment Systems, Inc. (Region C).

The RACs will not replace current audit entities. Rather, Medicare contractors [carriers, fiscal intermediaries, A/B Medicare administrative contractors (MACs) and durable medical equipment regional carriers (DMERCs)], program safeguard contractors (PSCs), Office of Inspector General (OIG), and/or quality improvement organizations (QIOs) will continue to perform audits. However, the RACs will *not* review a claim that has previously been reviewed by another entity.

## How Does the RAC Audit?

RAC audits focus on payment criteria established by CMS and include both automated claims history reviews from the agency's database, as well as complex clinical reviews of patient medical records.

When the RAC detects an overpayment through automated review, a refund may be requested from the provider without a request for medical records. However, the services subjected to the automated review must:

- Have a clear policy that serves as the basis for the overpayment. In this context, "clear policy" means that there is a statute, regulation, national coverage decision (NCD), coverage provision in a CMS manual, or local coverage determination (LCD) that specifies the circumstances under which a service will always be considered incorrectly paid; or
- Be based on a medically unbelievable service; or
- Occur when no timely response is received to a medical record request letter.

For example, an automatic refund request may occur when RAC data mining detects a pattern of billing multiple initial drug administration codes during a single patient

encounter. Because the coding guidelines are clear that only one initial code is reported per patient encounter, the RAC may not need to review medical records when this type of charging pattern is detected.

For more complex clinical reviews, the RAC will request medical records from providers where a likelihood of billing errors or inconsistencies exists. If an overpayment has occurred, the RAC will then extrapolate the audit findings over the provider's patient population to determine the amount of the refund.

Approximately 85 percent of Medicare overpayments identified by the RACs have been directly related to incorrect code assignment, determination of medical necessity, and/or a need to enhance documentation provided to support billed services. Other areas of focused review include noncovered services, duplicate charges, and incorrect payment amounts. Under the demonstration programs, the RACs had the option to use certified coders; however, for the permanent program, RACs will be required to employ certified coding experts.

## What Medical Records Are Reviewed?

The RACs generally identify areas of concern through data analysis, rather than random sampling. The data mining is performed by proprietary computer programs that operate in a similar manner to those programs that monitor credit card usage. A RAC cannot randomly select a record for review, but it can target a specific claim because it is high-dollar and contains other information that leads the RAC to believe it likely includes an overpayment. This "other information" may include, but is not limited to:

- Procedure code to diagnosis code discrepancies
- Contrasting charge to payment comparison
- Codes that have historically resulted in payment errors
- The belief that the claim payment was not consistent with Medicare payment policy.

Lastly, when required to complete a chart review, RACs are permitted to visit the provider location to complete the review of medical records.

Community cancer centers should develop a process to respond to requests for medical records within the 45-day requirement. In brief, here are the steps to follow.

First, log the RAC request. Next, copy the complete medical record or the information that supports the service under review. Submit all information on time and track the documentation to ensure it was received by the RAC. Finally, log the outcome of the review. If necessary, appeal the review following the RAC appeal guidelines.

If the RAC requests copies of medical records, but the provider does not supply them within 45 days, the RAC may consider the charges to constitute an overpayment by default. In addition, the RAC cannot review any claims that are more than three years old, and no claims prior to October 1, 2007, will be audited.

RACs are required to reimburse Prospective Payment System (PPS) providers and long-term care providers for photocopy charges associated with records requested for review. The reimbursement rate is 12 cents per page, and facilities are not required to submit vouchers to the RAC. Instead, the RACs will automatically issue payments to the hospitals for photocopying charges on a monthly basis. Checks will be issued by the RAC within 45 days of receiving the medical record.

## Appealing a RAC Decision

The appeal process under the RAC program may be more complex, time consuming, and expensive than that required for Medicare contractors, e.g., A/B MAC or FI decisions. The services of statisticians, lawyers, and other experts may be required to defend the practice, facility, or program. As a result, physicians, hospitals, and cancer programs should ensure that all documentation and data support payment *before* embarking on a RAC appeal.

When RAC findings are appealed, collection efforts cease until the contested overpayment amount is resolved. Of note, overpayments identified by the RAC can be repaid over a 12-month period, but any repayment plan must be negotiated with the Medicare contractor responsible for collecting the overpayment and may include interest on any outstanding balance. When determining whether to appeal the refund request, consider the following:

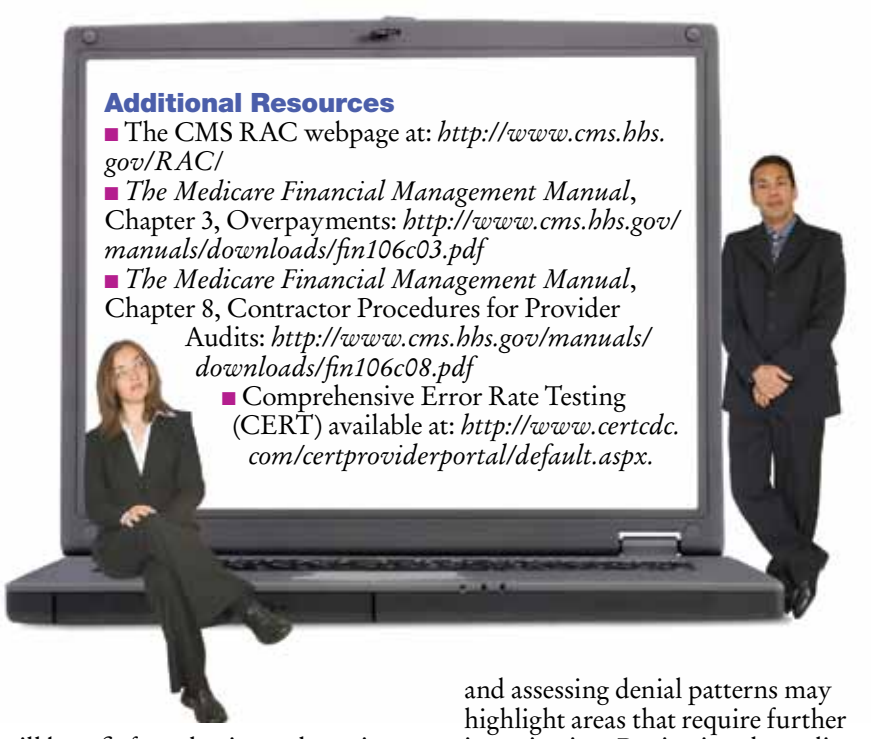
1. Ensure that there is sufficient documentation of medical necessity and documentation that the service was performed.
2. Determine whether the amount in question exceeds the cost of the appeal. Appeal costs may include, but are not limited to, an independent auditor review of the medical records in question, copying documents, preparing other information, and tracking progress.
3. Evaluate whether *not* appealing may appear to be an admission of guilt. By refunding the Medicare program, providers may indicate to other payers that an audit could be profitable for them as well.

Providers may want to develop a process or system to respond to requests for medical records, ensure all documentation is submitted during the initial appeal, and create a system to track outstanding reviews. These actions may also require ensuring that staff is trained to double check everything RAC auditors are reviewing and to compile coding guidelines and information to support the provider's billing. If the appeal fails, the provider must refund both the overpayment amount and any accumulated interest, at an interest rate of 11.75 percent. (This amount may be adjusted or revised due to economic changes.)

## Preparing for a RAC Audit

The RAC program is here to stay. As a result, physicians, hospitals, cancer programs, and other affected providers should implement a plan to prepare for the impact of a medical record review or refund request. Here is a method to T-R-E-A-T the organization *before* a RAC audit:

***Team.*** It takes more than a village to effectively and efficiently manage a RAC audit. Healthcare organizations can start by establishing a multidisciplinary RAC response team or steering committee. Although physician practices may not be as extensively impacted by a RAC review, they will

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still benefit from having a champion or leader in place who will log and control the information to and from the RAC in the event of a review. Depending on the size of the healthcare entity, taskforce members may include representatives of the compliance department, legal counsel, case management, internal auditing staff, health information management, information technology, ancillary department heads, finance, and/or patient financial services. A process should also be established to ensure that mail received from the RAC is delivered directly to the RAC coordinator or team leader without delay.

***Review.*** If the RACS have published problem areas as common in certain settings, the provider's compliance program should recognize that these are areas on which to focus internal reviews. For example, $2.4 million of the overpayments listed in the 2006 Status Report were related to incorrect coding for blood transfusion services. In addition, RAC audits detected problems with coding for injectable drugs and medical necessity documentation for the administration of Neulasta®. As a result, the practice, facility, or cancer program may want to focus its internal audits in these areas.

Although internal review efforts should not be limited to areas of concern previously identified by the RACs, these billing scenarios are a good place to start the review. Also, mining internal data and assessing denial patterns may highlight areas that require further investigation. Reviewing the audit results on Program for Evaluating Payment Patterns Electronic Report (PEPPER) and Comprehensive Error Rate Testing (CERT) reports may provide additional target areas that require review. The goal is to find any past errors and fix them before the RAC detects them.

***Educate.*** Physicians, hospitals, and support staff should be educated about RAC functions, claims filing guidelines, and their facility or practice compliance plan. Attention to local Medicare coverage requirements, medical necessity, code assignment, billing practices, and payment rules is essential. Also review chargemaster entries for pharmacy and ancillary services, and verify that dates of service and units were correctly billed. In cancer centers there may be a number of individuals who "capture charges," which constitutes the reporting of procedure codes. As a result, RAC education should be a part of standard in-service training associated with an active compliance program.

***Assess.*** All healthcare entities should have an active compliance infrastructure in place to support their compliance program. Additional tools, policies, and procedures may be required to perform an internal RAC risk assessment. It may also be necessary to eliminate, create, or update forms or templates used for medical record documentation and ensure that there are measurable criteria to identify coding and billing issues. Where detected through internal audits or reviews, these procedures may have been corrected, but all physicians and hospitals should ensure that current compliance is maintained in all aspects of billing and documentation.

***Track.*** If any problem areas are detected during the RAC preparation review, a corrective action plan must be developed to address these issues. This plan should include, when necessary:

- Developing education requirements
- Creating or updating policies and procedures
- Revising or implementing medical record documentation
- Training individuals or departments on the new procedures
- Establishing a process to monitor continued compliance.

In addition, the development of the RAC readiness review and/or the results of the internal audit may result in significant changes to the revenue cycle.

## Be Prepared

If the physician, cancer program, or hospital receives the attention of a RAC, it is important to set up a tracking mechanism that summarizes RAC activities for the healthcare organization and the results of the reviews. Although each entity will determine which statistics are important to track, common items include the number of medical record requests, the number of refunds requested, the dollar figure of the refunds, the status of any appeals, and the number of cases overturned on appeal.

Rather than considering the need to reduce risks and implement improvement strategies a burden to the healthcare organization, consider this an opportunity to review and improve the revenue cycle. Providers that are prepared for a RAC review will potentially 1) spend less money responding to the audit requests, 2) be prepared to challenge questionable overpayment determinations, 3) be ready to file timely appeals, and 4) encounter less disruption to their daily operations.

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