Recovery Audit Contractor (RAC) Readiness Manual

Arkansas Hospital Association
419 Natural Resources Drive
Little Rock, AR 72205

Disclaimers: What This RAC Readiness Manual Is and What It Is Not

It is essential for the user of this Manual to recognize that this RAC Readiness Manual is a work in progress and, as the climate continues to change and new players and issues are identified, this Manual will be updated to address such changes. It is, therefore, **VERY** important that the user of this Manual view the contents as tools to assist in his/her hospital's needs but not as the final authority on how to address a specific issue. The Manual user should consult with legal and risk management staff, RAC Readiness Team and CEOs to determine the best approach to address a particular issue for his/her facility.

We began preparing this document in October 2008. Laws, regulations and policies may have changed since it was last updated. **This RAC Readiness Manual is not intended to provide any type of legal advice to any user or organization. As previously stated, it is purely intended to serve as an example and provide tools that can be modified to fit the needs of a particular hospital or health care provider.**

RECOVERY AUDIT CONTRACTOR (RAC)
READINESS MANUAL

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PHIL E. MATTHEWS
President and CEO

MEMORANDUM

To: AHA Member Hospitals

From: Phil Matthews

Subject: RAC Manual

For well over a year, the Arkansas Hospital Association has been working with our members to help them prepare for visits from recovery audit contractors (RACs), who will review old Medicare claims and look for payment errors.

We know this process will be extremely challenging, and that is why we are pleased to announce a partnership with the Georgia Hospital Association to offer the **RAC Readiness Manual,** a comprehensive guide to the audit process and hospital preparations. The manual, one of the first of its kind in the United States, will provide details of exactly what hospitals can do and should be doing to be ready for the audit.

The AHA would like to acknowledge and thank the Georgia Hospital Association and the numerous individuals who contributed countless volunteer hours with the GHA to put the manual together.

Audits of Arkansas hospitals are scheduled to begin after the CMS outreach session that will take place sometime this October, and while that time may seem rather distant, the reality is that hospitals must ensure that they are not slowing down in their preparations. We at the AHA believe that the RAC Readiness Manual will serve as an essential tool in helping hospitals plan and prepare for the audits and make the process as smooth as possible.

Although the RAC audits may prove to be trying times for Arkansas hospitals, we are confident that, by working together, we can cope with any challenges that lie ahead.

419 Natural Resources Drive • Little Rock, Arkansas 72205 • 501-224-7878 • Facsimile 501-224-0519

INTRODUCTION

The Arkansas Hospital Association through the Georgia Hospital Association (GHA) is pleased to present this Recovery Audit Contractor (RAC) Readiness Manual (the "Manual") to its membership. This Manual is the result of numerous hours of work by a large multi-disciplinary team of Georgia hospital staff, attorneys and consultants.

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Background

- In the Fall of 2007, a multi-disciplinary team of GHA staff was tasked with developing a plan to prepare hospitals for the entrance of Recovery Audit Contractors (RACs) into Georgia. GHA developed a RAC preparedness strategy and work plan, which was presented and unanimously approved by GHA's Board of Trustees at its April 2008 meeting, including

- Organizing a multi-disciplinary RAC Task Force/Advisory Group to develop self-audit, educational and other tools, the product of which is this RAC Readiness Manual.

How the RAC Readiness Manual Was Prepared

GHA extends great appreciation to all who participated in the RAC Task Force and contributed in preparing this Manual. The list of Task Force Members can be found at the end of this Introduction. We especially recognize Mr. Jim Weadick, Administrator, Newton Medical Center, who has chaired the RAC Task Force meetings.

On April 3, 2008, a small RAC subcommittee, which included Anne Adams, Chief Compliance Officer at Emory Healthcare; Carolyn Regen, Interim Chief Compliance Officer, Gwinnett Hospital System; Valerie Barckhoff, formerly of Northside Hospital-

Cherokee; and GHA staff Robert Bolden and Liz Schoen; met to develop a draft table of contents for the RAC Readiness Manual to present to the entire RAC Task Force.

At its first meeting in June 2008, Jim Weadick successfully facilitated the meeting and achieved his goal of assigning specific tasks and subcommittee chairs to the various chapters of the Manual. All of the subcommittees worked diligently to develop the documents and tools in a timely and comprehensive manner. We also want to extend great appreciation to Carolyn Regen and Mark Guza, Of Counsel, Arnall Golden & Gregory, for their editorial assistance and time spent assisting GHA in reviewing the entire manual for substance and consistency.

Organization of the RAC Readiness Manual

The Manual is divided into various components beginning with this introductory section and identification of subcommittee members.

Chapter 1 of the Manual addresses how to get started and prepare for the RAC initiatives. Chapter 1 identifies who should be at the table, the identification of a RAC Coordinator, how to determine the team/committee members and suggested organization chart by function. This section also includes job description templates, budgeting issues and employee retention. We thank Co-Chairs **Carolyn Regen**, Interim Chief Compliance Officer, Gwinnett Hospital System, and **David King**, former Chief Compliance Officer, Central Georgia Health System (The Medical Center of Central Georgia), for serving as the Chair of the subcommittee, which included:

- Anne Adams, Chief Compliance Officer, Emory Healthcare;
- Troy Brooks, Chief Financial Officer, Newton Medical Center;
- Dan Hoodin, VP Managed Care and Chief Compliance Officer, Southern Regional Medical Center;
- Jill Jones, Chief Compliance and Internal Audit Officer, Archbold Health System;
- Jimmy Miller, Chief Compliance Officer, Crisp Regional Hospital; and
- Cindy Turner, CEO, Bacon County Hospital and Health System.

Chapter 2 provides practical tools for conducting a quick assessment of a hospital's operations, identifying useful reports, regulations, top ten DRGs and other materials. It includes an audit section and provides an example of how to conduct an internal audit of observation. It provides a questionnaire that can be used by hospitals in evaluating their RAC Readiness from a process perspective. We would like to thank **Kim Lansford**, formerly Chief Compliance Officer, Saint Joseph's Hospital of Atlanta, and **Debi Weatherford**, Director of Internal Audit, Piedmont Healthcare, for co- chairing this subcommittee. Subcommittee participants were:

- Jan Jameson, Director of Chief Compliance & Internal Audit, Northeast Georgia Health System, Inc.;
- Carolyn Regen, Interim Chief Compliance Officer, Gwinnett Hospital System;
- Rick Tully, VP Revenue Cycle, Newton Medical Center;

- Kim Lansford, Formerly VP & Chief Compliance Officer of Saint Joseph's Hospital of Atlanta;
- Valerie Barckhoff, formerly of Northside Hospital-Cherokee
- Jorge Hernandez, VP of Administrative Services and Chief Compliance Officer, Northside Hospital System;
- Marjorie Scott, Chief Compliance Officer, West Georgia Health System; and
- Robert Bolden of GHA.

Chapter 3 outlines the process and legal issues involved with conducting a legal risk assessment and investigation. In this section there is a discussion of various peer review issues, attorney/client privilege issues, statistical sampling issues and recommendations regarding concerns with the self-disclosure process. It addresses the compliance officer's role versus the legal counsel's role in the RAC initiatives. Lastly, this section discusses how these issues could also lead to false claims and other government investigations. GHA thanks **Mitch Mitchelson**, Partner, Alston + Bird, LLP and **Wade Miller**, Senior Associate, Alston + Bird, LLP for authoring this chapter.

Chapter 4 is an extremely important chapter for hospitals and those entities preparing for the RACs. The chapter addresses in detail the legal standard for defining medical necessity and provides practical considerations in producing documents to the RACs. It includes a useful table in the appendix that addresses common medical necessity denials made during the RAC demonstration so that providers can learn to develop processes to avoid such denials. Many thanks to **Amy Fouts**, Attorney, McKenna Long & Aldridge, LLP for chairing the subcommittee. Also included on the committee were:

- Tracy Field, Partner, Health Care Group, Arnall Golden & Gregory, LLP; and
- Jane Snecinski, Principal, Center for Health Innovation, Noblis.

Chapter 5 provides an evaluation of Arkansas law and Medicare payment policy issues arising under the Case Management Assignment Protocol (CMAP). While this may not seem to apply directly to the RAC issues, it will be extremely useful for hospitals to understand in trying to develop operational solutions to avoiding RAC scrutiny. AHA and GHA thank **Mark Guza**, Of Counsel, Arnall Golden & Gregory LLP for his comprehensive and easy-to-understand analysis of the risks involve for a Georgia hospital in adopting a Case Management Assignment Protocol (CMAP).

Chapter 6 addresses RAC appeals and provides a practical guide on how to respond to a RAC letter, timeline data requests, copies and reimbursement issues. GHA thanks **Mark Guza**, Of Counsel, Arnall Golden and Gregory, LLP, who chaired this subcommittee. The other subcommittee members included:

- Jackie Kendinger, Compliance and Privacy Counsel, University Health Care System;
- Jimmy Miller, Chief Compliance Officer, Crisp Regional Hospital; and
- Jane Snecinski, Partner, Noblis Consulting, for their participation.

Chapter 7 specifically addresses post-acute rehab hospitals, SNFs, outpatient rehab issues and LTACHs. GHA would like to thank **Jane Snecinski** of Noblis who chaired this subcommittee. The other subcommittee members included:

- Sherry King, Administrator of Long Term Care, Bacon County Hospital and Health System;
- Lou Little, WellStar Windy Hill Hospital;
- Elbert McQueen, CEO, Central Georgia Rehabilitation Hospital; and
- Lydia Williams, Director, Health Information, Shepherd Center.

Chapter 8 covers education of hospital board members, executives and staff. GHA staff developed different educational PowerPoint presentations to cater to different audiences. The Board and executive level presentations are shorter and more general. GHA has prepared a much longer presentation for hospital staff needing to know more details. These presentations appear on GHA's website and include draft questions for board members as well as case studies from some of the RAC demonstration states. Arkansas Hospital Association members shall receive the power point electronic copy of these and can adapt them to their facility as appropriate.

Lastly, the RAC Readiness Manual includes various appendices and exhibits provided under the headings listed as follows:

Appendix A – CMS Documents

Appendix B – AHA Advisories

Appendix C – Connolly & Associates RAC Auditor for Region C Presentations

Appendix D – Website Resources

RAC Task Force

Name	Title	Institution
Jim Weadick, Chair	Administrator	Newton Medical Center
Anne Adams	Chief Compliance Officer	Emory Healthcare
Valerie Barckhoff		Formerly of Northside Hospital-Cherokee
Tim Beatty	Director of Management, Accounting & Reimbursement	WellStar Health System, Inc.
Troy Brooks	Assistant Administrator/Fiscal Services	Newton Medical Center
Tracy Field	Partner, Health Care Group	Arnall Golden Gregory LLP
Amy Fouts	Attorney	McKenna Long & Aldridge, LLP
Joette Gay	Director of HIM/UM	Meadows Regional Medical Center
Mark Guza	Of Counsel	Arnall Golden Gregory LLP
Kathleen Hall	Audit & Compliance Services	Central Georgia Health System
Tony Herdener	VP, Systems & Finance/CFO	Northeast Georgia Health System, Inc.
Jorge Hernandez	VP of Administrative Services/Chief Compliance Officer	Northside Hospital System
Dan Hoodin	Vice President	Southern Regional Medical Center
Jan Jameson	Director, Compliance & Internal Audit	Northeast Georgia Medical Center, Inc.
Jill Jones	Director, Internal Audit & Compliance	Archbold Medical Center
Jackie Kendinger	Compliance & Privacy Counsel	University Health Care System
David King	Compliance/Privacy Officer	Central Georgia Health System
Sherry King	Administrator of Long Term Care	Bacon County Hospital & Health System
Kenneth Kunze, M.D.	Senior VP/Chief Medical Officer	WellStar Health System, Inc.
Alison Land	Director for Clinical & Operational PI	Floyd Medical Center
Kim Lansford	VP & Chief Compliance Officer	Formerly of Saint Joseph's Health System
Lou Little	Senior VP/Administrator	WellStar Windy Hill Hospital
Elbert McQueen	CEO	Central Georgia Rehabilitation Hospital
Jimmy Miller	Dir., Practice Management/ Corporate Compliance Officer	Crisp Regional Hospital, Inc.
Wade Miller	Attorney	Alston & Bird, LLP
Mitch Mitchelson	Partner	Alston & Bird, LLP
Ruth Nash	Compliance Officer/Risk Manager	Morgan Memorial Hospital
Carolyn Regen	Interim Chief Compliance Officer	Gwinnett Hospital System
Marjorie Scott	Chief Compliance Officer	West Georgia Health System
Larry Sims	CFO	Colquitt Regional Medical Center
Jane Snecinski	Principal, Center for Health Innovation	Noblis
Michael Spake	Dir., Corporate Compliance & Privacy	MCG Health
Rick Tully	PPS Manager	Newton Medical Center
Cindy Turner	CEO	Bacon County Hospital & Health System
Judy Ware	Director, Audit & Compliance	Medical Center of Central Georgia
Debi Weatherford	Director of Internal Audit	Piedmont Healthcare
Lydia Williams	HIM Manager	Shepherd Center

GHA Staff Support: Robert Bolden, Martha Harrell, Vi Naylor, Rhett Partin, Liz Schoen, Temple Sellers, Karen Waters, Bill Wylie

CHAPTER 1:

HOW TO GET STARTED

AUTHORS:

Carolyn Regen – Co-Chair	**Gwinnett Hospital System, Inc.**
Dave King – Co-Chair	**Central Georgia Health System**
Anne Adams	**Emory Healthcare**
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Mark Guza	**Arnall Golden and Gregory LLP**
Dan Hoodin	**Southern Regional Medical Center**
Jill Jones	**Archbold Medical Center**
Jimmy Miller	**Crisp Regional Hospital, Inc.**
Cindy Turner	**Bacon County Hospital & Health System**
Debi Weatherford	**Piedmont Healthcare**

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Chapter 1

How to Get Started

Introduction:

The Recovery Audit Contractor (RAC) Coordinator is the single most critical position in the organization for the success of the hospital's efforts to meet the challenges presented by the RAC program. Defining the Coordinator's tasks and identifying appropriate candidates are among the first steps in readying the organization to deal with the RAC. Lessons learned from the RAC Demonstration Program indicate that a hospital must from the outset be prepared to process and track numerous requests for voluminous medical records in short timeframes, and each with a separate deadline. In addition, decisions must be made about appeals, which require preparation of narrative justifications of the hospital's actions supported with exhibits. Each appeal is subject to its own series of deadlines. In order to meet these challenges, a hospital must have a system and an administrator to ensure that separate functions operate in coordination and in a timely manner. In the demonstration program many denials were issued based on the hospital's inability to perform the basic task of keeping up with deadlines and obtaining extensions of time when necessary.

We know from the Demonstration Program that many operational features of the RAC are invented and revised on short notice. Because of this, it is essential for the success of the hospital's efforts that the RAC Coordinator maintain close relationships with both RAC and CMS representatives, and to obtain answers quickly to operational issues that surface during implementation. The RAC Coordinator should also be able to identify government systemic problems that may rise in RAC processes and be able to communicate these issues quickly and effectively. He or she must be able to convey changes in hospital policies and procedures to effect change to the hospital's RAC operations in response to internal issues or governmental issues.

Faced with this daunting prospect of the RAC program, the initial tasks in preparation will be to design the hospital system and define the functions of the RAC Coordinator within that system. This chapter of the manual addresses these two key steps in order to rapidly implement your RAC program, and also contains a host of sample documents and forms that can be adapted for immediate use in your facility.

A. Who Should be at the Table

To begin basic preparations for the RAC activities, the facility should appoint a RAC Coordinator and a specific team or committee tasked with the facility's RAC "readiness" implementation.

1. Identify a RAC Coordinator

The facilities that participated in the national RAC Demonstration Project recommended appointing a RAC Coordinator. In order to achieve the greatest success in dealing with the RAC audits, the facility should designate a specific person to be accountable for coordinating and communicating with the RAC. The facility RAC Coordinator could report directly to any of the following departments as appropriate to the facility's organizational structure:

- Corporate Compliance
- Revenue Management/Integrity
- Health Information Management
- Internal Audit
- Care Management/Utilization Review

2. RAC Coordinator Job Description

The selection of the RAC Coordinator will depend upon several factors, many of which will be unique to each facility. In general, the Coordinator should be a well-organized, detail-oriented person that is familiar with the facility's medical records, utilization review/care management process, coding and billing departments and the CMS regulations applicable to the facility.

The decision to employ a RAC Coordinator will also depend upon the circumstances within each facility and its infrastructure. Should the RAC Coordinator also function as an Auditor, the Coordinator should have audit and coding certification/experience and be familiar with Medicare billing and medical necessity regulations.

> **Practice Tip**
> **SAMPLE READY-TO-USE DOCUMENTS (at end of this Chapter):**
> Sample Job Descriptions and Tasks (Exhibits: I, I-A and II)

3. Defining the Functions of the RAC Coordinator

In an effort to fully explain the importance and complexities that challenge the RAC Coordinator/Committee in dealing with the RAC, a comprehensive RAC Coordinator Flow Chart and Appeals Chart (Exhibit IV in this chapter) depicting the various anticipated functions and processes that will be necessary for a facility to implement and manage.

Hospitals are encouraged to print these flow charts and share with senior leaders and the facility's Board of Directors (you may want to download and customize

for your facility). These flow charts can help to support the justification for hiring additional resources to manage the RAC requests, responses, data base tracking process, and appeals.

a. <u>RAC Coordinator Functions</u>

In general the RAC Coordinator role/functions/tasks include the following:

- Serves as the liaison between the facility and the RAC as well as CMS.
- Receives all RAC written communications, monitors requests and responses.
- Oversees/maintains the RAC request/response data base; assists with the timeliness of the response/submission of records and outcomes.
- Tracks other CMS contractor medical record requests and facility MAC/F.I./Carrier settlements and advised RAC claims are off-limits to RAC.
- Coordinates with all relevant departments to trigger an internal review of records.
- Coordinates the RAC Committee/Team.
- Coordinates the facility's decision to appeal, and tracks each medical record appealed.
- Assists the Chief Compliance Officer with communications to external legal counsel or auditors.
- Regularly reports to the Corporate Compliance Committee the status of the RAC initiative, findings, appeals (successful & unsuccessful), total dollars recouped and recovered, and opportunities for immediate improvements.

> **Practice Tip**
> **SAMPLE READY-TO-USE DOCUMENTS (at end of this Chapter):**
> Sample RAC Coordinator Flow chart (Exhibit IV).
> Analyze the RAC Coordinator Flow Chart to identify processes that you may need to develop or evaluate for RAC readiness!

b. <u>Decision to Appeal a RAC Denial</u> (Also see RAC Readiness Manual Chapter 6 for more detailed discussion of appeal processes.)

One of the important functions of the RAC Coordinator could be assisting with identifying denials that should be appealed. Based on CMS reports, providers successfully overturned a large percentage of denials through the appeals process.

Hospitals that receive RAC determinations of allegedly incorrect payment that the hospitals believe are unjustified, should give serious consideration to appealing the determinations through the administrative appeals process discussed below.

According to a Report issued by CMS in September 2008, updating its Evaluation of the 3-Year RAC Demonstration Program, of the Connolly denials appealed through June 30, 2008, 54.6% of the appeals involving Part A claims and 64.7% of the appeals involving Part B claims were decided favorably to the provider. The combined Part A and Part B rate was 57.4%. Furthermore, since CMS included appeals filed but not yet decided in calculating the percentage of provider-favorable decisions, the actual percentage of provider-favorable decisions to decisions-issued is even higher.

In managing the appeals process, hospitals may decide that some denials should not be appealed, or that some are best handled by their own staff. Hospitals/facilities may also consider third-party consultants and attorneys as options. Ultimately, this is a business decision for each provider, as there are costs associated in terms of staff time and lost revenues.

If you elect to manage appeals in-house, it is critical that cases be tracked closely. Dedicated staff should be designated and buy-in from clinicians should be obtained. Typically, providers have considered the following circumstances as meriting third-party expertise:

- Denials of large amounts of reimbursement (such as those based on statistical extrapolation from a sample). Because of the impact on the organization, these denials should be referred to legal counsel for evaluation so that any grounds for reversal will not be overlooked.

- Denials that could have significant collateral consequences to the organization should also be referred for third-party review. An example of such a denial would be one that, even if for a small amount of reimbursement, bases the denial on a determination that a common practice of the hospital is incorrect.

- Involvement of legal counsel is recommended when there are indications that a matter under RAC review may become the subject of assertions by the government of civil liability beyond mere overpayment or of criminal liability, such as under the False Claims Act.

Close interaction between the RAC Coordinator, the compliance office, and legal counsel during the initial months of the RAC program would be beneficial in facilitating the development of well-attuned processes to distinguish between and deal with routine and extraordinary RAC determinations. (See Chapter 6 for a detailed discussion on the Appeal process.)

Practice Tip
SAMPLE READY-TO-USE DOCUMENT (at end of this Chapter):
CMS Denial Management Flow Chart – Exhibit IV - A. Use this document to guide your facility through the complex and time-sensitive steps of the CMS government appeals process.

4. Determine the RAC Team/Committee Members

To begin basic preparations for the Recovery Audit Contractor-generated activities, the facility's senior leadership should appoint a specific team or committee tasked with the facility's RAC "readiness" implementation.

A RAC team/committee task is to provide the facility-wide guidance for the development and implementation of a RAC readiness program, provide support to a designated RAC Coordinator, and report all RAC related activities/findings to the Corporate Compliance Committee. It may be necessary to formulate sub-committees with members from the clinical or operations departments to assist with the design and implementation of the RAC program.

The RAC team members should be representative of the departments likely to be impacted by the RAC audit activities and that already have accountability for responding to various types of medical records or audit requests that the facility routinely receives.

Some organizations may want to supplement the work of the RAC Committee/Team and consider utilizing existing internal auditors or assembling a cross-functional audit team that includes key people that are knowledgeable in the process to be reviewed. An audit team can be a valuable asset by ensuring that adequate technical expertise exists to conduct any sample reviews and that the reliability of the results. Evaluate now if your facility has the expertise to conduct internal reviews.

Practice Tip
SAMPLE READY-TO-USE DOCUMENTS (at the end of this Chapter):
Exhibit V - RAC Team Composition – Large or Small Hospital
Exhibit VI - Sample RAC Committee Charter
Exhibit VII - Sample RAC Activities by Department – Sample Matrix

B. Budgeting Issues

The budget planning process is another important function that a facility should address when getting started with preparing for the RAC activities. The facility may want to take into consideration the following factors when attempting to estimate the cost of all of the associated RAC activities:

- Processing and responding to the requests
- Software to track the claims requested
- Additional personnel
- Expenses for copying and mailing of medical records
- Denials and appeals management and tracking
- Use of external consultants or legal services
- Expense of interest charged by CMS for claims that are lost on appeal

The Volume Disclaimer

It is important to note at the outset that, like any other budget related exercise, volume is the critical unknown element. Each facility may experience wide variations in volume of RAC requests from one year to the next and certainly any individual facility's experience may differ widely from a peer facility.[1] The attached budgets were built upon a premise where the volume of RAC cases increased from 5% of Inpatient Medicare Admissions in year one up to 20% in year three. (See Exhibit X at the end of this Chapter for volume examples).

1. Predictors

   In order to work at narrowing the level to which a hospital is guessing at volumes to expect from RAC activity there are RAC audit targets that can be analyzed in advance. For instance, if a hospital has a high percentage of Inpatient Medicare claims that include three day stays with discharge to Skilled Nursing Facility, they may expect a higher volume of RAC claims activity. Likewise, a facility with a significant level of Chest Pain cases with a one day stay could expect to see elevated RAC claims activity. It is strongly suggested that each hospital attempt to conduct an internal evaluation of these and other targeted areas in order to determine expected volume of RAC claims.

2. Volume Compounding

   Another complicating factor with the volume expectation is the compounding effect over time. More specifically, a hospital or provider can expect that

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[1] CMS clarified medical records request limits for 2009 are for: **IP, IRF, SNF and Hospice** 10% of average monthly Medicare claims (maximum of 200 records) per 45 days per NPI number.
Other Part A Providers (Outpatient Hospital and Home Health) limit is 1% of average monthly Medicare services maximum of 200 records per 45 days per each NPI number. **Physicians:** solo practitioner: 10 medical records per each 45 days; Partnership of 2-5 individuals: 20 medical records per 45 days; Group of 6-16 individuals: 30 medical records per 45 days; Large Group (16+ individuals) 50 medical records per 45 days.
Other Pat B Providers (DME, Lab) 1% of average monthly Medicare services per 45 days.

claims requested during Year One will not have run through the entirety of the appeals process during Year One. So therefore, you will begin to see Year One claims clogging the work process into Year Two and possibly into Year Three. Hospitals in the demonstration states have consistently reported that the RAC claims tracking process grows exponentially more difficult and costly as time passes and new claims are being added to the volume of already pending claims appeals.

3. Work Force Adaptation to Volume

   The attached budgets are based upon an assumption of having existing staff handle the RAC claims activity during a period of time when the volume may not overwhelm them. With a budgeted first year volume of 130 RAC cases, an even distribution of the claims would indicate 2.5 cases per week hitting the hospital's existing staff. If an individual hospital experienced a consistent and somewhat even flow of RAC claims requests, then it is possible that existing staff may adapt to handle that volume. It goes without saying then, that should the work flow not hit evenly, the hospital will have to adapt quickly to meet the staffing needed to respond timely to all requests.

   It is important to recognize in a contemplation of RAC claims volume, that hospital employed staff may not be the only workers impacted by that volume. As an example, if a hospital out-sources services such as Record Release, that hospital may need to consider in advance the contractor's ability to respond to volume fluctuations and what that response will cost the institution.

   In year two, the attached budget essentially assumes a doubling of the volume of cases being handled when compared to Year One and then that doubles again for Year Three. The budget contemplates Year Two increases in productive work hours for Utilization Review, Coding, Physician Document Consulting, HIM technicians (or record release service), and Patient Accounting.

4. Outside Contracted Services

   There are numerous job duties related to the RAC activity that a hospital may want to consider handing off to an outside service. Tasks such as Medical Staff education, Record retrieval and copying, Appeals Management and Legal representation are some of the areas where outside help may be incorporated into the effort. The attached budget contemplates purchasing outside assistance in the areas of Physician Documentation Education and Legal work to represent the hospital's interests in the appeals process.

   The area of physician education should not be overlooked for it may be the most effective method to stem the tide of losses brought on from RAC activity. There is a definite opportunity to adopt "Lessons Learned" from RAC claims based upon patterns that the contractors exhibit.

Practice Tip

SAMPLE READY-TO-USE DOCUMENTS (at the end of this Chapter):

Exhibit VIII Small Hospital Sample Budget
Exhibit IX Large Hospital Sample Budget

The attached sample budgets may differ significantly from the actual RAC impact experience for any given hospital/facility. However, it should serve to focus attention on certain elements of revenue loss or expenses to be incurred so that each hospital can adapt local knowledge into the equation and improve the forecasting process.

5. Reserves

- Currently, the necessity of "reserving cash" for future payments to RAC contractors is a topic of discussion for many organizations. One suggestion is to use a calculation based upon the amount of money repaid by providers in the demonstration states divided by the bed size of the provider. This would give a rough estimate of any anticipated repayments. However, the accuracy would be very suspect due to the many variables within the RAC audit process.

- A second proposal is to calculate a reserve based upon the Medicare claims history of the provider. Suggested methods are to use 0.3% to 1% of claims made in the past 12 months.

- Another method proposed is to establish a cash account into which funds are deposited on a periodic basis. Admittedly, this method is not scientific, but does have the potential of accumulating funds to help maintain cash flow in the event that repayment is demanded.

- Some hospitals may want to take the stance, simply to do nothing at all. Many external auditors have indicated that they will not accept a reserve account for RAC. The argument is that there is no real basis for calculating the reserve—that establishing a reserve account is an admission by the provider that a demand for repayment by the RAC contractor may have merit. This is a position that could be detrimental to the appeals process.

- The bottom line is that each provider needs to discuss this with their external auditors, senior leadership, and its Board of Directors, and determine the organization's tolerance for financial risk.

C. Release of Information

The process for gathering the requested documents and then releasing them to the RAC Contractor will be a critical feature of any implementation plan and RAC program. The current scope of work indicates that CMS will institute a medical record request limit. The limit differs by provider type and volume of claims (See Exhibit X at the end of this chapter for volume examples).

- One example has been to set the limit for a 150 – 249 bed hospital at 50 inpatient charts per 45 day period. Whether or not the limit will increase as the bed size increases can only be answered by CMS. However, it is reasonable to expect that the limit will increase with an increase in bed size. The experience of the demonstration states indicates that larger hospitals can expect to receive requests for 75 – 100 medical records within a 45 day period. It is important to remember that this will be in addition to the requests that providers currently receive from CERT contractors, Medicaid auditors, insurance auditors and, in the near future, Medicaid Integrity Program contractors.

- Bearing all of this in mind, each provider will need to assess the record release capacity of their organization. Below are some examples of process questions to pose:

    - Will the current process be able to accommodate additional 50 - 100 medical records within a 45 day period?
    - Who will be responsible for gathering and copying the requested information? Remember that these records will potentially be needed for the appeals process, so 2 copies will most probably need to be made.
    - Where will these records be housed?
    - Who will be responsible for maintaining the inventory of these records?

- Many large organizations currently contract with national companies for all release of information functions. These organizations will need to review their contracts with an eye toward cost containment and capacity. Some operational questions that should be posed include:

    - Will the current vendor be able to handle the increased volume with current levels of staffing?
    - How will billing for the RAC requested medical records be handled? The RAC is authorized to pay $0.12 per page for medical records copies.
    - Will the release of information vendor bill the contractor or will the organization?

- Is the vendor able to submit electronic copies of the records rather than mailing paper copies?
- If the vendor sends paper copies to the RAC contractor, how will documentation regarding the mailing of the records and receipt by the contractor be maintained?

- Organizations that currently handle release of information through an in-house process will need to answer the same questions. One further step may be to investigate the need for contracting with a release of information vendor.

D. Employee Retention

The facility should evaluate the possibility that the RAC may attempt to hire certain critical staff such as: Coders, Utilization Management Nurses, Nurse Auditors, Physicians, Data Analyst, etc. The facility can proactively review the following key retention areas to make change as necessary to retain qualified/experienced staff:

- Evaluate existing market salary rates for these critical positions and take action for salary increases if applicable.
- Develop flexible work schedules.
- Implement "work from home" strategies that include minimal required shifts during the month to be on-campus, and create structure in order for management to monitor productivity and quality of work.
- Explore remote access to electronic medical records and the use of voice recognition technology/software.
- Develop unique employee rewards, incentives or retention promotions packages and tuition reimbursement.
- Explore "quality of life" enhancements available to staff (i.e. child care on campus, dry cleaning, banking, etc.).

The facility may want to involve, as applicable, their General Counsel, Human Resources, and Medical Staff Office to address the issue of "moonlighting" for a RAC (or any other government claims auditing contractor). Such an activity would pose significant conflicts of interest issues.

Summary:
This chapter provides an abundance of ready-to-use information and helpful practice tip tools to assist you in getting your RAC program implemented. All you need to do is customize the documents to meet the needs of your organization and you are ready to go!

Exhibit I

Position Title: **Recovery Audit Contractor (RAC) Coordinator/Nurse Auditor**

Position Code:

Reports to: Chief Compliance Officer

Supervises: No line of supervision

Effective Date:

Position Summary:
Under the direction of the Chief Compliance Officer, responsible for establishing workflows, policies and procedures, and the communication plan for the facility interactions with Medicare's Recovery Audit Contractors (RAC). The Coordinator is also responsible for designing a tracking system to ensure that responses to RAC requests occur within the required timeframe and to monitor the impact of the RAC on the facility's resources. Other duties to include conducting audits to identify areas where changes to organizational practices, policies or procedures might be needed to enhance organizational efficiencies and effectiveness in preparation for the RAC.

Minimum Qualifications:
- Bachelors degree in nursing from an accredited program, required
- Masters degree in nursing, business or other health care related field preferred
- Current Registered Nurse License from appropriate State.
- Relevant Experience in a hospital setting
- Strong knowledge of state and federal laws and regulations
- Understanding of CMS coverage and payment methodologies
- Excellent oral and written communication skills
- Advanced computer proficiency
- Excellent organizational skills and attention to details
- Certified Professional Coder (CPC), Certified Coding Specialist (CCS), or similar coding certification preferred
- Previous audit experience preferred
- Knowledge of InterQual and Principles of Managed Care preferred.

Essential Position Competencies/Functions:

Adaptability	Oral Communications
Customer Service	Planning and Organization
Business Ethics & Compliance	Problem Solving
Dependability	Quality
Analytical Skills	Team Work
Initiative	Use of Technology
Innovation	Written Communications
Job Knowledge	Technical Competencies
Judgment	

Exhibit II

HEALTH SYSTEM X

POSITION TASKS

Position Title: Recovery Audit Contractor (RAC) Coordinator

Position Code:

Position Tasks:

- Oversee the RAC review process beginning with the initial medical record request to final resolution. This includes monitoring and tracking the final disposition of the claim for each medical record requested through the appeals process if necessary.

- Lead and coordinate RAC Committee efforts, which will follow a multidisciplinary approach.

- Identify and maintain a database of medical records that will not be eligible for the RAC to review.

- Perform audits of medical records and recognize documentation, billing, and coding trends that require further review.

- Conduct in-depth analyses of audit and RAC findings to identify opportunities for billing and coding education and improving organizational practices, polices, or procedures in preparation for the RAC.

- Communicate with RAC and CMS staff in regard to RAC issues. The Coordinator will be the facilities' liaison to CMS and the RAC or MAC related matters.

- Identify circumstances where the assistance of legal counsel should be sought, taking into account the amount of funds involved in the issue, the possible collateral consequences to the facility of an unfavorable resolution of the matter, and the possibility the government will assert further civil or criminal liability in regard to the matter under RAC review.

Exhibit III

RAC Position Job Description

Recovery Audit Contractor Coordinator will facilitate the Recovery Audit Contractors implementation and response team. Develop workflows, policies and procedures, and the communication plan to prepare for RAC requests and denials. Responsible to monitor overall RAC effect on the facility. Develop changes to organizational practice, policies, and procedures as needed. Develop a tracking system to ensure that responses to RAC requests occur within the required time frames. The RN Case Manager aspect will be accountable for coordination of the diverse aspects of patient care to achieve the highest quality and most cost effective outcomes. Demonstrates knowledge and skills necessary to provide are appropriate to the ages of the patients/clients served, and ability to provide care according to departmental policies and procedures. Promotes effective utilization and monitoring of health care resources. Assumes a leadership role with the interdisciplinary team to achieve optimal outcomes. Performs other related duties as deemed competent.

Requirements

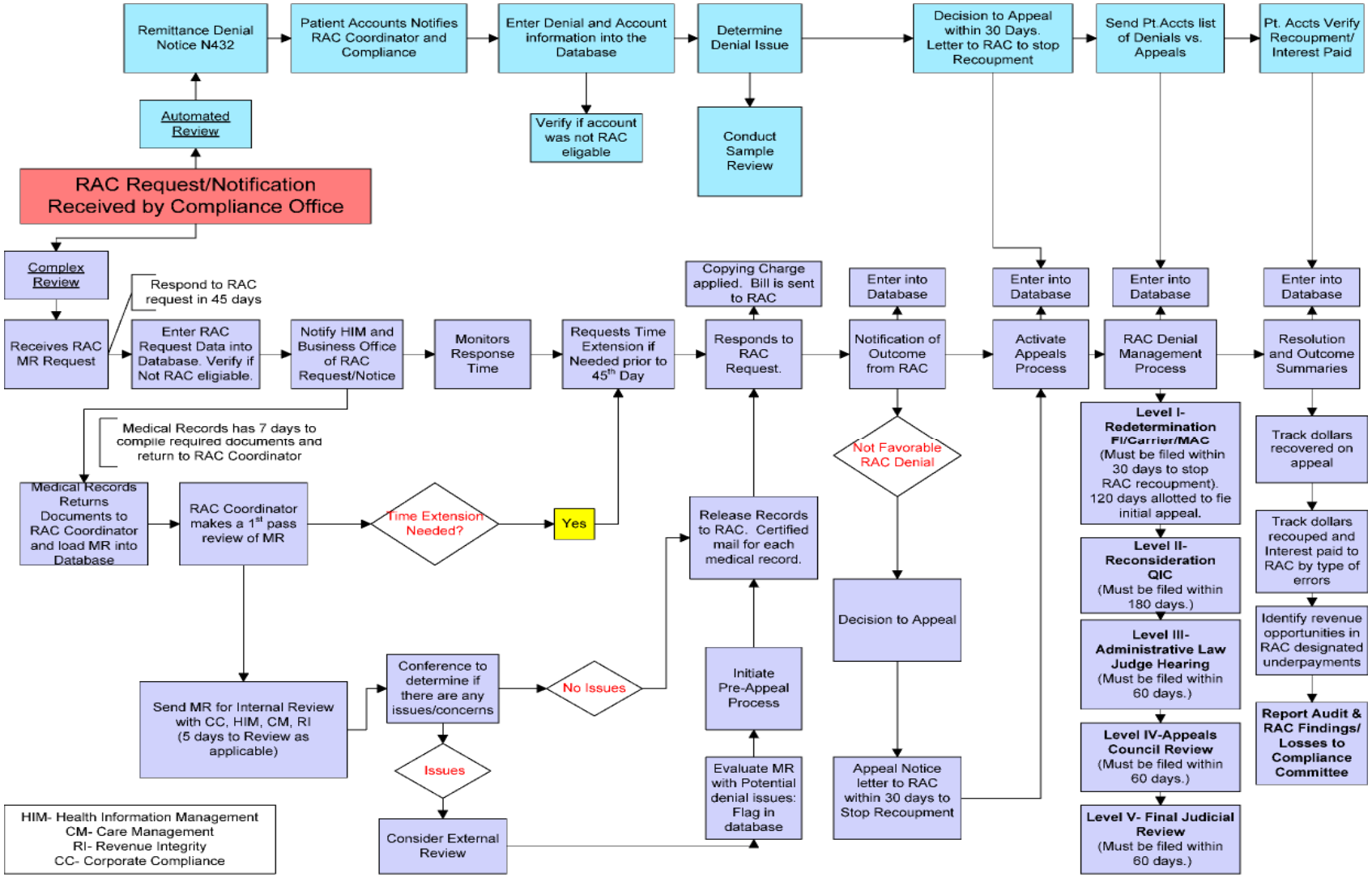
Education: Graduate of an accredited school of nursing, BSN degree preferred

Experience: Minimum 3-5 years in acute care; leadership, case management and/or home health experience

License/Registration: Current license - Registered Nurse (or Compact state License) or obtain a license.

Other: Computer skills required. Highly organized individual that is a self-starter. Knowledge of Utilization Management process, coding, medical necessity criteria is preferred.

Exhibit IV - RAC Notification and Response Flow Chart



February 05, 2009

Exhibit IV – A

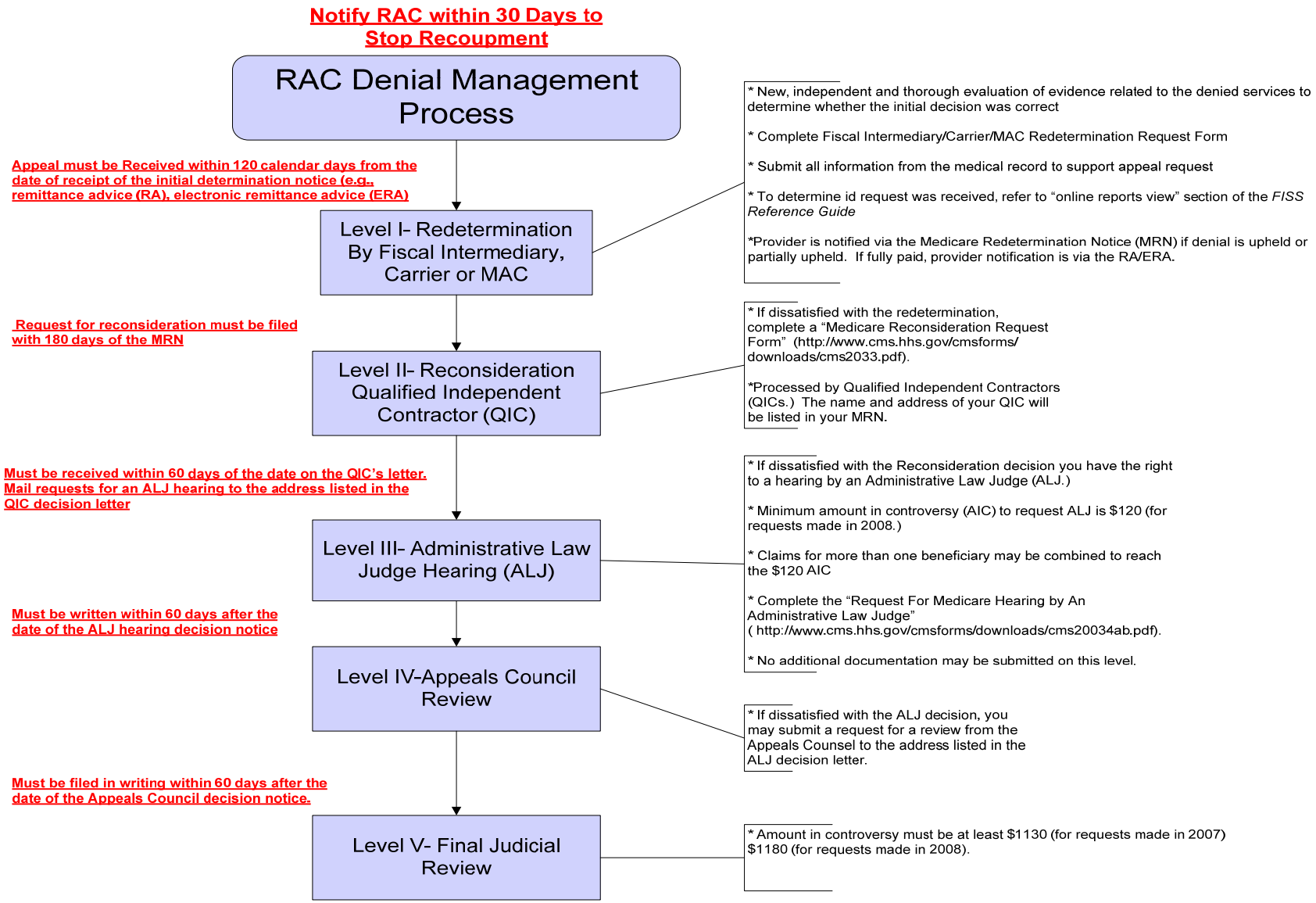


Exhibit V

Suggested RAC Team Composition – Example 1 - Large Hospital

1. Revenue Management/Revenue Integrity – Team leader
2. Compliance Officer
3. DRG Coordinator
4. Coding Manager
5. Case Management/Utilization Review
6. Chief Medical Officer or a designated Utilization Review Physician
7. Financial Services – with Medicare regulations experience
8. Patient Financial services manager
9. Rehab. Unit coordinator
10. Case manager
11. HIM/Release of information manager

Suggested RAC Team Composition – Example 2 - Small Hospital

1. HIM representative
2. Compliance Officer
3. Patient Accounts
4. Risk management
5. Quality Assurance
6. Case management / Utilization Review
7. Revenue Integrity
8. Physician
9. Legal representative

Exhibit VI

Example - RAC Team/Committee Charter

Members:
RAC Coordinator (Reports to Corporate Compliance or other department)
Chief Compliance Officer
Compliance Auditor
Case Management/Utilization Management
Health Information Management Coding
Medical Records Manager
Revenue Management/Revenue Integrity
Patient Financial Services
Charge Master Coordinator
Internal Audit (Optional)
Nurse Auditor
Chief Medical Officer

The Committee provides facility wide guidance and support to the RAC Coordinator to ensure that the requests from the Recovery Audit Contractor (RAC) is managed and responded to in a timely manner and that the appeals options is evaluated and initiated for each affected claim when applicable.

The committee also serves to facilitate the analysis of:
Claims data to identify opportunities for improvement;
RAC findings;
Appeals results; and
Outcome trends and financial impact.

The committee shall report regularly to the Corporate Compliance Committee.

Exhibit VII - RAC Activities by Department – Sample Matrix

Department	Receives Initial RAC Request	Copy Medical Record	Copy Itemized Bill & UB04	Review Issues Coding/ Medical Necessity	Compile Records	Submit Records to RAC	RAC Committee & Members	Appeal Process / Tracking	Track Payment for copying	RAC Database Manager
RAC Coordinator	X			X	X	X	X	X		X
Compliance Office	X			X	X	X	X	X		
Internal Audit				X			X			
Revenue Management/Integrity				X			X			X
Patient Financial Services			X				X		X	
Medical Records		X			X		X		X	
External Copying Vendor (May need additional back-up vendor)		X			X				X	
HIM Coding				X			X			
Care Management				X			X	X		
Nurse Auditor				X				X		X
Chief Medical Officer							X	X		
Data Support Analyst								X		X
Utilization Review Physician				X			X			
In-House Legal							optional	X		
External Consultant(s)								X		
External Legal								X		

Exhibit VIII - Small Hospital RAC Budget 2009

Small Hospital (100 beds)
RAC Impact Budget
Fiscal 2009, 2010 and 2011

	2009	2010	2011
Medicare Volume	2600	2730	2865
RAC Audit Volume (1)	130	273	573
Costs:			
Salaries (3)			
Utilization Review	$ -	$ 10,400.00	$ 21,632.00
Coding	$ -	$ 9,100.00	$ 18,928.00
Physician Document Consulting	$ -	$ 4,000.00	$ 8,320.00
HIM technicians	$ -	$ 6,240.00	$ 12,979.20
Patient Accounting	$ -	$ 6,240.00	$ 12,979.20
Total Salaries	$ -	$ 35,980.00	$ 74,838.40
Benefits (4)	$ -	$ 10,074.40	$ 20,954.75
Professional: (5)			
Outside Vendor Physician Consulting	$ -	$ 30,000.00	$ 50,000.00
Legal Fees	$ 5,000.00	$ 15,000.00	$ 50,000.00
Other: (ie RAC Tracking Tool)	$ 5,000.00	$ 7,500.00	$ 15,000.00
TOTAL BUDGET IMPACT BY YEAR	$ 10,000	$ 98,554.40	$ 210,793

NOTES:
(1) Projecting RAC review of Medicare cases at 5% for year one, 10% for year two, and 20% for year three. Each hospital should have a better idea of their potential review volume by looking at patient volume within the focus areas.

(2) In the sample budget, the first year's review volume is handled by existing staff as the projection calls for RAC volume of only 2.5 cases per week on average. In year two, with RAC activity doubling, the projection calls for approximately 10 hours per week of added staff in the areas impacted. In year three, the time commitment doubles and includes a 4% increase due to market/inflation.

(3) Benefits are based upon 28% of the salary impact.

(4) Professional fees are budgeted to increase with RAC volume. Most significantly, an outside physician coding and documentation consultant is included. The purpose would be to address weaknesses exposed in RAC audits so as to avoid further exposure to overturned cases.

*Consider that revenue can be taken back by the RAC due to denials.
Sample formula to calculate impact:

Using the above sample budget, the revenue impact is calculated as the number of reviewed cases, times the percentage of RAC denials on those cases, times the hospital's reimbursement per case.

Using this sample budget number, it projects a 25% RAC denial rate on the cases reviewed though this would certainly vary by hospital depending upon types of cases being reviewed and the hospital's relative strength or weakness in documentation and care patterns.

First year potential revenue lost: $269,100

Second year potential revenue lost: $565,110

Third year potential revenue lost: $ 1,186,110

Exhibit IX - Large Hospital RAC Budget 2009

Large Hospital (600 beds)
RAC Budget
Calendar year 2009, 2010 and 2011

	2009	2010	2011
Medicare Volume	15600	16380	17,190
RAC Audit Volume (1)	300	800	800
Costs:			
Salaries (3)			
Utilization Review	$ 25,000	$ 60,000	$ 63,500
Coding Reviewer	$ 25,000	$ 50,000	$ 52,000
HIM technicians (in-house)	$ -	$ 6,000	$ 8,000
Patient Accounting RAC Coordinator	$ 30,000	$ 60,000	$ 64,000
Total Salaries	$ 80,000	$ 206,000	$ 217,500
Benefits (4)	$ 22,500	$ 57,700	$ 60,900
Professional: (5)			
Outside Consulting (Physician, etc.)	$ -	30,000 60,000	60,000 80,000
Legal Fees	$ 5,000	$ 25,000	$ 75,000
Other: (i.e., RAC Tracking tool)	$ 5,000.00	$ 17,500.00	$ 25,000.00
TOTAL BUDGET BY YEAR	$ 112,500	$ 396,200	$ 518,400

NOTES: Exhibit IX
(1) Projecting RAC review of Medicare cases at 2.5% for year one, 5% for year two holding steady for year 3. Each hospital should have a better idea of their potential review volume by looking at patient volume within the focus areas.

(2) In the sample budget, the first year's review volume is handled by existing staff as the projection calls for RAC volume of only 2.5 cases per week on average. In year two, with RAC activity more than doubling, the projection calls for approximately full time staff in the areas impacted. Year three includes an increase due to market/inflation.

(3) Benefits are based upon 28% of the salary impact.

(4) Professional fees are budgeted to increase with RAC volume. Most significantly, an outside physician coding and documentation consultant is included. Depending on the facility there may be an opportunity for an employed physician to consult in-house. The purpose would be to address weaknesses exposed in RAC audits so as to avoid further exposure to overturned cases. Additionally the physician consultant can participate in internal reviews for risk analysis or to determine correct documentation in a concurrent review. Professional fees increase due to potential increased appeal opportunities

Exhibit X
CMS Example RAC Medical Record Request Limits

Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
  - **10%** of average monthly Medicare claims (max of 200) per 45 days

- **Other Part A Billers** (Outpatient Hospital, HH)
  - **1%** of average monthly Medicare services (max of 200) per 45 days

- **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 Billers** (DME, Lab)
  - **1%** of average monthly Medicare services per 45 days

Inpatient Hospital, IRF, SNF, Hospice (by NPI)

- 10% of average monthly Medicare paid claims per 45 days
- Maximum of 200 medical records per 45 days

  - Example 1: Local Community Hospital
    - 1,200 Medicare paid claims in 2007
    - Divided by 12 = average 100 Medicare paid claims per month
    - x 10% = 10

    Limit = 10 medical records per 45 days

  - Example 2: Major Medical Center
    - 12,000 Medicare paid claims in 2007
    - Divided by 12 = average 1,000 Medicare paid claims per month
    - x 10% = 100

    Limit = 100 medical records per 45 days

Other Part A Billers (Outpatient Hospital, Home Health, etc.) (by NPI)

- 1% of average monthly Medicare paid services per 45 days
- Maximum of 200 medical records per 45 days

- Example 1:
  - 1,500 Medicare paid services in 2007
  - Divided by 12 = average 125 Medicare paid services per month
  - x 1% = 1.25

  Limit = 2 records/45 days

- Example 2:
  - 360,000 Medicare paid services in 2007
  - Divided by 12 = average 30,000 Medicare paid services per month
  - x 1% = 300

  Limit = 200 records/45 days (capped at the maximum)

Physicians (by NPI)

- Solo Practitioner

  Limit = 10 medical records/45 days

- Partnership of 2-5 individuals

  Limit = 20 medical records/45 days

- Group of 6-15 individuals

  Limit = 30 medical records/45 days

- Large Group (16+ individuals)

  Limit = 50 medical records/45 days

Other Part B Billers (DME, Ambulance, Lab) (by NPI)

- 1% of average monthly Medicare paid services per 45 days
- Maximum of 200 medical records per 45 days

  - Example 1:
    - 1,500 Medicare paid services in 2007
    - Divided by 12 = average 125 Medicare paid services per month
    - x 1% = 1.25

    Limit = 2 records/45 days

  - Example 2:
    - 360,000 Medicare paid services in 2007
    - Divided by 12 = average 30,000 Medicare paid services per month
    - x 1% = 300

    Limit = 200 records/45 days (capped at the maximum)

Source CMS website RAC documents postings

CHAPTER 2:

IDENTIFYING THE ISSUES –

A QUICK-START RISK ASSESSMENT

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Table of Contents

Identifying the Issues – A Quick-Start Risk Assessment

A. Gather Information and Resources

In order to adequately prepare for the RACs, organizations should utilize the reports and resources that are available or which can be easily created to conduct a quick risk assessment.

A variety of data is available to health care providers. Some of the information is created internally and other generated externally. Below are some, but not all areas where data or information can be obtained. These materials have been broken down into the following sections: governmental reports, internal reports, miscellaneous resources and special areas of focus. This is not meant to be an exhaustive list. It is meant to serve as a guide for quickly identifying the issues that will direct your RAC preparedness efforts.

1. Governmental Reports

a. Program for Evaluating Payment Error Patterns Electronic Report (PEPPER)

As stated on the HPMP Resources[1] website (http://www.hpmpresources.org/PEPPER/AboutPEPPER/tabid/1209/Default.aspx), the Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides summary statistics of administrative claims data on the Centers for Medicare & Medicaid Services (CMS) target areas (areas likely to have payment errors due to billing, DRG coding and/or admission necessity issues).

Hospitals can use PEPPER to review their data for the current quarters and the previous three fiscal years for each of the CMS target areas, comparing their performance to that of the other short-term, acute-care prospective payment system (PPS) hospitals in their state (or in the nation, in the case of long-term care hospitals). Hospitals can also use PEPPER to compare their own data across years to identify significant changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems and identify target areas where length of stay is increasing. PEPPER can help hospitals achieve CMS' goal of reducing and preventing payment errors.

i. What is PEPPER?

- A tool that supports the Hospital Payment Monitoring Program (HPMP).
- A Microsoft Excel file containing hospital-specific data for CMS target areas that are often associated with Medicare payment errors.
- PEPPER prioritizes findings to provide guidance on the areas that a hospital may want to focus auditing and monitoring efforts. Hospitals are encouraged to conduct regular audits to ensure that the medical necessity

[1] HPMPResources.org was developed to provide information, tools, and data to hospitals and health care providers related to payment error prevention. This web site is maintained by TMF Health Quality Institute, under contract with CMS as the HPMP Quality Improvement Organization Support Center (QIOSC). *See* http://www.hpmpresources.org/.

for admission and treatment is documented and that bills submitted for Medicare services are correct.

- PEPPER was provided to short-term acute-care hospitals and long-term care hospitals, prior to October 2008, through Medicare's Quality Improvement Organization (QIO) for the state. Currently, the Support QIO has issued PEPPER reports and it is unknown at this time which entity will provide this.

ii. Who benefits from PEPPER?

PEPPER can be a useful tool for many different staff members who share responsibility for reducing and preventing Medicare payment errors.

Hospital CEOs and Administrators

Use PEPPER to:

- Access tables and graphs displaying hospital performance over time in comparison with other hospitals in the state.
- Review hospital-specific data and aggregate statewide (or nationwide, in the case of long-term care hospitals) comparative claims data for target areas.
- Track and trend administrative data to identify changes in billing practices and Medicare reimbursement for CMS target areas.

Chief Financial Officers

Use PEPPER to:

- Identify areas of potential overpayments and underpayments
- Identify DRGs with a high proportion of short-stay outliers (for long-term care hospitals).
- Compare hospital length of stay data to statewide data, or nationwide data, in the case of long-term care hospitals.
- Assess Medicare reimbursement for target areas, track and trend over time.

Compliance Officers

Use PEPPER to:

- Review hospital-specific data for target areas identified by CMS as at high risk for payment error.
- Identify areas of potential overpayments and underpayments.
- Help prioritize areas for compliance auditing and monitoring.
- Access data tables and graphs displaying hospital performance over time in comparison with other hospitals.

Utilization Review/Quality Improvement Staff

Use PEPPER to:

- Identify areas that may be in need of closer study to determine whether the admission was medically necessary, procedure or treatment was performed in the appropriate setting.
- Monitor hospital readmission rates to assist in identifying opportunities for improvement related to quality of care.
- Identify target areas where the average length of stay is increasing (or decreasing, in the case of long-term care hospitals).
- Aid hospital efforts to improve medical record documentation

iii Health Information Management (HIM) Staff

Use PEPPER to:

- Identify potential DRG overcoding and undercoding.
- Identify DRGs that are problematic on which the hospital may want to focus auditing and monitoring.
- Access tables and graphs displaying hospital performance over time in comparison with other hospitals, which can be used for educational training activities.
- Prioritize areas for coding compliance auditing and monitoring.
- Aid hospital efforts to improve medical record documentation.

The QIO distributes the PEPPER report on a regular basis via a designated channel for individuals in each hospital. Designated individuals are typically the hospital's QualityNet administrator, utilization review/case management director and compliance officer.

In preparation for the RACs, organizations should review and monitor their hospital's PEPPER results and implement measures to eliminate any concerns that might arise after reviewing the report(s).

SPECIAL NOTE: Effective August 1, 2008, QIOs will no longer be responsible for implementing HPMP as responsibilities are being transferred to either the Fiscal Intermediaries or Medicare Administrative Contractors (MAC). At the time of publication, it is unknown if the FIs or MACs will be distributing a similar report. Check the CMS or QIO web-site for updates.

b. Comprehensive Error Rate Testing (CERT)

In addition to HPMP, CMS also established the **Comprehensive Error Rate Testing (CERT)** program. The CERT program measures the error rate for claims submitted to Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs). A national error rate is calculated using a combination of data from the CERT contractor and HPMP with each component representing about 60% and 40% of the total Medicare FFS dollars paid, respectively.

The Department of Health and Human Services, Office of Inspector General (OIG) produced Medicare FFS error rates from 1996 - 2002. The OIG designed a sampling method that estimated only a national dollar weighted FFS paid claims error rate. Beginning in 2003, CMS elected to calculate a provider compliance error rate in addition to the paid claims error rate. The provider compliance error rate measures how well providers prepare Medicare FFS claims for submission.
CMS calculates the **Medicare Fee-For-Service error rate** and estimate of improper claim payments using a methodology the OIG approved. The CERT methodology includes:

- Randomly selecting a sample of approximately 120,000 submitted claims.
- Requesting medical records from providers who submitted the claims.
- Reviewing the claims and medical records for compliance with Medicare coverage, coding, and billing rules.

Internally tracking and trending CERT requests and responses provide a hospital with information that can be helpful in preparing for RACs.

All public reports produced by the CERT program are available through the "CERT Reports" link on its website (www.CERTprovider.org).
The web site is operated by the CERT documentation contractor. Monthly CERT newsletters, medical record request example letters, and more are available. The purpose of the CERT Newsletter is to provide for an exchange of information among the Centers for Medicare and Medicaid Services (CMS), the CERT Review Contractor (CRC), the CERT Documentation Contractor (CDC), Medicare Administrative Contractors (MACs), Affiliated Contractors (ACs) and Providers. The Newsletter is not intended to set CMS policy or replace CMS directives. The newsletter is published quarterly by CDC. Archived copies are available on the CERT Website.

The CERT contractor began reviewing claims for the purpose of measuring error rates for acute IPPS hospital and LTACH claims on April 1, 2008.

It is anticipated that the fiscal intermediaries (“FIs”) and the Medicare Administrative Contractors (“MACs”) will begin reviewing acute IPPS hospital and LTACH claims, for the purpose of determining the appropriate payment due and preventing or reducing improper payments beginning summer 2008.

Website References:
http://www.cms.hhs.gov/CERT
www.CERTprovider.org

c. Payment Error Rate Measurement (PERM) Requests

CMS implemented the Payment Error Rate Measurement (PERM) program to **measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP)**. PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). For PERM, CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected State Medicaid

and SCHIP fee-for-service (FFS) and managed care claims. In FY 2006, CMS reviewed only fee-for-service Medicaid claims; however, in FY 2007, CMS expanded PERM to include reviews of fee-for-service and managed care claims, as well as beneficiary eligibility, in both the Medicaid and SCHIP programs.

CMS published the final rule for PERM on August 31, 2007. This regulation responds to public comments on the August 28, 2006 interim final rule and sets forth State requirements for submitting claims and policies to the CMS Federal contractors for purposes of conducting fee-for-service and managed care reviews. This final rule also sets forth the State requirements for conducting eligibility reviews and estimating case and payment error rates due to errors in eligibility determinations.

Not every State is reviewed by PERM every year. CMS created a 17-State rotation cycle to lessen the burden on States. Each State will only participate in PERM once every 3 years.

CMS has selected the States that will be reviewed for Medicaid and SCHIP improper payments in FYs 2007, FY 2008, and FY 2009. CMS's State selection process allows States to plan for the reviews as each State will be selected once and only once every 3 years for Medicaid and SCHIP. The following shows the States selected in which CMS will measure improper payments in these programs over the next 3 years.

- **FY 2007:** North Carolina, Georgia, California, Massachusetts, Tennessee, New Jersey, Kentucky, West Virginia, Maryland, Alabama, South Carolina, Colorado, Utah, Vermont, Nebraska, New Hampshire, Rhode Island

- **FY 2008:** New York, Florida, Texas, Louisiana, Indiana, Mississippi, Iowa, Maine, Oregon, Arizona, Washington, District of Columbia, Alaska, Hawaii, Montana, South Dakota, Nevada

- **FY 2009:** Pennsylvania, Ohio, Illinois, Michigan, Missouri, Minnesota, Arkansas, Connecticut, New Mexico, Virginia, Wisconsin, Oklahoma, North Dakota, Wyoming, Kansas, Idaho, Delaware

Website Reference:
http://www.cms.hhs.gov/PERM

As hospitals prepare for RACs, consider tracking and trending PERM requests to assist in identifying areas that need to be addressed.

d. Medicaid Integrity Contractors (MICs)

Through the DRA, Congress has provided CMS with resources to establish the Medicaid Integrity Program. MIP represents CMS' first national strategy to detect and prevent Medicaid fraud and abuse in the program's history. Under the leadership of the Center for Medicaid & State Operations (CMSO), the agency will design a program to combat fraud, waste, and abuse in Medicaid. This initial Comprehensive Medicaid Integrity Plan(CMIP)

will guide CMSO's efforts to fulfill that mission. There are two broad operational responsibilities under this new program.

- **Reviewing the actions of those providing Medicaid services**
- **Providing support and assistance to the States to combat Medicaid fraud, waste, and abuse**

e. Zone Program Integrity Contractors (ZPICs)

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) imposed Medicare fee-for-service contracting reform and directed CMS to use competitive measures to replace the current Medicare fiscal intermediaries and carriers with Medicare administrative contractors (or MACs). Recently, CMS also established 7 zones based on the newly established MAC jurisdictions and created new entities, called Zone Program Integrity Contractors (ZPICs), to perform program integrity functions in the 7 zones. The ZPICs are expected to perform program integrity functions for Medicare A-D, DME, home health, hospice and the Medi-Medi program.

f. Medicare Administrative Contractors (MACs)

On January 7, 2009 CMS announced that Cahaba Government Benefit Administrators, LLC (Cahaba GBA) has been awarded the contract for the combined administration of Part A and Part B Medicare fee-for-service claims in Jurisdiction 10 (J10) comprised of Alabama, Georgia and Tennessee. Cahaba GBA (headquartered in Birmingham, AL) will function as a Medicare Administrative Contractor (A/B MAC) and have the responsibility to process the Medicare fee-for-service claims with greater administrative efficiency and effectiveness. MACs in other regions have not been announced at the time this manual was written.

Cahaba GBA will have the following subcontractors:

- Allison Payment System, LLC will provide printing and mail services;
- Emdeon Business Services will provide intelligent character recognition and data entry services;
- Mayer Hoffman McCann will conduct SAS 70 and annual compliance audits, and
- Dr. James E. Strong will assist the Contractor Medical Director

Providers should go to the MACs website to sign-up for the list serve communications and published bulletins. The bulletins are a helpful tool for providers to gain awareness of MAC directives and areas of audit interest.

Web site reference: http://www.cahabagba.com/

g. Office of Inspector General (OIG)

The OIG publishes a Work Plan for each fiscal year. This publication describes activities that OIG plans to initiate or continue with respect to the programs and operations of the Department of Health and Human Services (HHS) in the next year. It is imperative that

providers print this plan each year and review it to determine if any of the OIG audit priority areas may be an issue at your facility or practice.

Web site reference: http://oig.hhs.gov/

h. Additional Document Requests (ADR)

CR4022 allows Medicare contractors (carriers, DMERCs, and intermediaries) to request additional documentation about the patient's condition before and after a specific service to gain a more complete picture of the patient's clinical condition.

If a Medicare contractor cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an Additional Document Request (ADR).

Medicare contractors will not deny other claims related to the documentation of the patient's condition before and after the claim in question, unless they review and give appropriate consideration to the actual additional claims and associated documentation.

Occasionally, a hospital will receive multiple ADRs for the same type of service (e.g. CT scans of the abdomen). When this happens, it is reasonable to assume that the hospital has been placed under a Probe Review. When this happens, the Medicare contractor may have identified a trend that is determined to warrant further review. Hospital claims for the sample of claims under review may be held by the contractor until an error rate is determined for the sample. It is imperative that the hospital respond to all documentation requests in a timely manner as failure to provide documentation is included in the overall error rate and will result in claim denial.

Monitoring, tracking and trending ADR requests can provide an organization with identification of weaknesses in their documentation processes which can assist with RAC preparation.

2. Arkansas Hospital Association Resources

a. Newsletters and Online Updates

The AHA will provide updates to member hospitals as we learn more about the RAC process in our weekly newsletter, *The Notebook*, and in our periodic RAC-specific newsletter, *RAC Facts*. As they become available, additional RAC resources will be posted on the AHA webpage, www.arkhospitals.org. RAC educational programs will be planned to provide updates to members following the first meeting with Connelly Consulting in the fall. While this information will be included in the newsletters, all workshops and Webinars will be posted at www.arkhospitals.org/calendar.htm.

CMS also provides an email update subscription related to RACs. Individuals can subscribe to the CMS RAC email update list by clicking "receive email updates" and subscribing to the "Recovery Audit Contractor" list under "Research, Statistics, Data, &

Systems" available through the following link: http://www.cms.hhs.gov/AboutWebsite/20_EmailUpdates.asp#TopOfPage.

b. Listserve

The AHA also plans to create an email listserve for hospital RAC coordinators to exchange information. As hospitals identify their RAC coordinator and notify the AHA, they will be added to the AHA RAC listserve so that they can be linked into discussions with their peer RAC coordinators at facilities across the state.

3. Internal Reports

Internal reports can be helpful in assessing risk as part of RAC preparation. In addition to being familiar with audits conducted through the corporate compliance or internal audit departments, hospitals might want to assess the information obtained in their denials management reports, charge description master and utilization review committee.

a. Denials Management Reports

Denials have an immediate impact on cash flow. The ability to obtain denial information and disseminate it throughout an organization effectively and efficiently is imperative to your facilities continued operations.

There are two ways in which a hospital can capture denials. One is through manual posting of rejections that come from payors in a hard copy. The other is by capturing information that is retrieved from electronic ANSI 835 transactions. Both mechanisms should be in place at your facility to ensure complete capture of all denied claims.

b. Manual Postings

A hospital should have a limited number of transaction codes established to post denials based on payor EOB information. The transaction codes should map back to root cause and/or owners of an issue, such as admissions, or coding, or billing. The Cash Applications area plays a distinct role in the process as they are responsible for posting the denial information from the EOB's. Hospitals may need to increase staffing levels when attempting to post denials manually, as **each** denial should be recorded. The importance of this fact cannot be understated as some payors have time limits on responding to denied claims. If a claim is resubmitted and all the denials have not been resolved, it is possible that an unresolved denial may prevent reimbursement of the entire claim.

c. 835 Postings

The use of electronic 835 ANSI transaction sets will allow your facility to capture denial information in an automated fashion. The same transactions codes should be used for posting purposes here as well as those used in the manual posting process. The purpose of this is so that you can create a single report that encompasses all denial information, both manual and electronic, and report on the root cause and/or owner.

It must be understood that only Medicare recognizes 835 transaction set as the reason for the denial. Every other payor may have unique methodology and denial information. Thus, you will almost always find that the 835 denial reason captured can be linked to a number of denial reasons at the payor level. It is important to note that what is captured on the 835 report may not necessarily be the true denial reason. For instance, in Georgia, when Medicaid reports a denial of an undocumented alien they use an 835 transaction code that indicates the patient is not a member. Upon further review you will find the hospital may receive payment from Medicaid, however, program restrictions require documentation that supports an emergency condition.

Every payor will have these types of issues so each facility must take steps to ensure they have the ability to review the actual EOB to capture the payor specific denial.

Once the denials have been captured and posted to the patient accounting system, some form of report must be generated to summarize the denial data and a process implemented to correct or adjust the claim.

Denial reports should indicate why claims were denied, how much was denied, and the root cause and/or owner of the denial. If using the 835 claims data, denials can be generated by payor and transaction code, to create a payor specific summary of issues. The reporting of manual postings should do the same. The best organizations are going to blend these two processes together through the use of patient accounting transaction codes to ensure they capture a complete and comprehensive listing of identified issues.

d. Denial Correction Process

Once a facility has created reports of denials, the actual claims need to be reviewed and corrected if possible. Information should be provided to the root cause owner, and educational processes implemented to prevent future denials.

As discussed previously, a claim could have multiple denials that touch several departments. Due to this, it is best if there is a single unit responsible for coordinating claims corrections. This area should ensure all issues are submitted together and timely filing guidelines are met. If a claim denies for both coding corrections and a request for medical records it is imperative both are sent at the same time to ensure prompt payment.

e. Root Cause Identification and Owner Review and Training

The use of established reports will allow your facility to identify the root cause and owner of various types of denials. The owner is a specific department and the one responsible rectifying the denial. Every area should get regular feedback regarding denial information originating from the unit responsible for posting the denials. Educational seminars and training material should be prepared to address the various issues while utilizing the denial reports to determine if behavior is changing.

f. RAC Impact

It is suggested that denials be captured and reported for all denials made by the RAC. Items such as the number of accounts reviewed, associated charges, potential losses, prevented recoveries, number of accounts at each stage of the appeal process, DRGs under review, and other related data. If reviewed consistently it will allow the users to determine how the institution is fairing in relation to the RAC process.

In preparation for RACs, providers should be tracking and trending their denial data and implementing processes to eliminate denial patterns. It is through the consistent review and feedback loop to each area that the ability to change processes and create "clean" claims can occur. Organizations that consistently track and trend denials and follow the processes above to eliminate the causes of the denials, add another tool to their RAC preparedness toolbox.

4. Charge Description Master

The Charge Description Master (CDM) is a database intended to provide a mechanism by which services and charges are allocated to specific patients and enable the production of detailed bills and claims.

CDMs typically contain unique charging numbers that are associated with a Current Procedural Terminology (CPT) code when one is available. CPT codes are "a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other care providers." For all charging codes, there is an assigned Revenue Code. Other information included in the CDM is typically current and historical charge information.

It is of the utmost importance that the CDM contain a current and comprehensive listing of all services including drugs and biologicals, supplies, and procedures provided or performed by the hospital. The CDM must be kept current with all state and federal regulations as well as coding rules.

The RAC auditors will be using the information supplied by the facility to make initial assessments on filed claims. The CDM is the starting point of where claim data. Each hospital should regularly perform a comprehensive review of the CDM to ensure services have been captured and coded appropriately. If this process becomes routine, exposure to inappropriately coded service items and subsequent over/underpayments will be minimized.

5. Utilization Review Committee Reports

The facility's RAC Coordinator/Committee should begin work as soon as possible with its Utilization Review (UR) department to perform sample reviews (5-10 claims) of some of the UR related errors/issues (listed below) that were targeted or identified during the RAC demonstration project.

The facility should consider obtaining the following data reports to conduct sample reviews and evaluate the following key areas:

a. Analyze the Payment Error Prevention Patterns Report (PEPPER) prepared by the Quality Improvement Organization (QIO). Determine if the facility is at risk for a high volume of:

- One-day stays (identify affected DRGs and if inpatient verses observation was appropriate)
- Same day re-admits and all readmissions within 10 days (evaluate identified cases for potential early discharge issues verses failed treatment plan)
- Skilled Nursing Facility (SNF) 3-day qualifying stay (was the stay medically necessary or just a hospitalization to qualify for SNF admission)

b. The facility's accuracy of use of the admission screening criteria (e.g. InterQual®)

c. The use of Condition Code 44 (is correctly applied to the claim or omitted)

d. Medical record documentation and if the claim clearly reflects the correct discharge status billed (Discharge-to-home vs. Transferred, etc.).

e. Admissions for scheduled/elective procedures that are eligible for either inpatient or outpatient surgery.

Upon completion of these focused sample reviews, the facility can identify risk areas that may need further investigation to determine the extent of the aberrancy. Prompt attention to any identified deficiencies will allow the facility to proactively seek further guidance from the Compliance Department and implement a performance action plan.

6. Top RAC-Related Diagnosis Related Groups (DRG) Analysis and Top RAC Outpatient Procedures or Services

According to the CMS Final RAC Demonstration Report (July 11, 2008), the RAC reviewed claims that they considered likely to contain improper payments based on OIG/GAO/CERT reports, and their knowledge of the health care industry. The RAC reviewed claims in order to identify overpayments and underpayments that could be detected *without medical record review (automated review)* using their proprietary automated review software algorithms. Additionally, the RAC anticipated claims that contained *likely* errors and requested the medical record from the provider to conduct a *complex review*.

a. RAC Top DRGs:

Specifically, the RAC targeted certain DRGs due to the likelihood that the coding was incorrect; either the selection of the principal diagnosis was wrong or a DRG designated as complicated or with a comorbidity and had only one secondary diagnosis coded on the claim (which would not be likely). A list of the top DRGs focused on by all of the RACs participating in the Demonstration project has been compiled in Table 1 (See attached in this chapter).

It is important to note that some of the DRGs reviewed by the RACs (listed on Table 1) are no longer valid, and some DRGs (effective October 1, 2007, government fiscal year 2008) now have a corresponding designated Medicare Severity (MS) DRG.

When referring to the RAC Demonstration Project DRG audit results data, Table 1 serves as a valuable "cross-walk" of the transition that certain DRGs have undergone. For example, the RAC focused on DRG 143 – Chest Pain, and found that this DRG was associated with one-day stays that were likely to have been incorrectly billed as an inpatient claim verses an outpatient observation claim. The DRG 143 now has an MS-DRG 313; therefore the permanent RAC auditors would be looking at claims trends for DRG 313 and not DRG 143. Likewise, the facility will want to evaluate claims data on or after October 1, 2007 for DRG 313 and not DRG 143.

Keep in mind that Post Acute Facilities (Skilled Nursing Facilities-SNFs, Inpatient Rehabilitation Facilities-IRFs, Home Health-HHs,) have different claims payment systems than acute care hospitals and the medical necessity of the service could be a focus of the RAC audits.

b. RAC Top Outpatient Procedures:

Through data mining techniques, the RAC targeted certain outpatient procedures with easily identified billing errors; such as services billed with the wrong units of service. The RAC identified specific Current Procedural Terminology (CPT) codes that can only be billed as one (1) unit of service for each day and therefore considered these types of errors to be a clear improper payment and contacted the provider to pay any overpayment amounts. Table 2 (See attached to this chapter), is a list of the top CPT codes focused on by the RACs participating in the Demonstration project.

For example, the RACs targeted the drug, Neulasta, because each 6mg dose of the drug equates to one (1) unit. Hospitals erroneously billed Medicare for six (6) units of this drug instead of one unit. The RACs targeted other services such as "Speech Therapy Initial Evaluation" because this procedure can only be billed as one (1) unit per each evaluation session. The RAC Demonstration project identified that hospitals erroneously billed "Speech Therapy Initial Evaluation" in 15 minute increments (one unit for each 15 minutes) instead of the required one unit regardless of the time spent performing the initial evaluation.

The RAC coordinator/committee in conjunction with the facility's HIM coders and/or external coding auditors should begin work as soon as possible to perform sample reviews focusing on the DRGs and coding errors that were targeted / identified by the RAC Demonstration project's automated and complex reviews.

As with any audit activity, the facility's staff should discuss the audit plan and scope with Corporate Compliance prior to engaging in any type of audit activity.

Practice Tip
SAMPLE READY-TO-USE DOCUMENTS:
Quick-start your facility's medical necessity and coding risk assessment now by using the following Tables to guide you in your initial claims data selection for a sample review:
Table 1 – RAC Demonstration Complex Audits – Top Hospital DRGs
Table 2 – RAC Top Automated Review Medical Necessity – Hospital Outpatient Procedures

Table 1: RAC Demonstration Complex Audits – Top Hospital DRGs

Invalid DRGs	DRG	Principal Diagnosis	ICD-9 Procedure Code	Description	FY08 MS-DRG
	76			Other Respiratory System O.R. Procedures with CC	166, 167, 168
	82			RESPIRATORY NEOPLASMS	180,181,182
	85			Pleural effusion w/CC	186
	88			COPD	190
	120			Other Circulatory System O.R. Procedures	264
	124			CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	286
	125			Circulatory disorders except AMI, w/ cardiac cath	287
	127	402.91, 428.0		CHF	293
	143	786.50, 786.59		Chest Pain	313
	210			HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE	480
	217		86.22	Excisional Wound debridement & skin graft Exct Hand for musculo-conn tissue disorder	463, 464, 465
	243			Back Pain	551, 552
	263			SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS	573
	296			NUTRITIONAL & MISC METABOLIC DISORDERS AGE	640
	397			Coagulation disorders	813
	440			WOUND DEBRIDEMENTS FOR INJURIES	901, 902,903
	515			Cardiac defibrillator implant w/o cardiac cath w/o MCC	227
	150, 151			Peritoneal lysis of adhesions-must document "extensive or dense"	335, 337
	182, 183			ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17	391, 392
	263, 264		86.22	O.R. Procedure: Excisional debridement wound, infection, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC ;	573, 574 ,575
415, 416	417, 575, 576			Septicemia age > 17 w/ Mechanical Vent support -Without Mechanical Vent support	870, 871, 872
	468*	038 - 038.9		Extensive OR procedure unrelated to principal diagnosis	981, 982, 983
	477*			Non-extensive OR procedure unrelated to principal dx	987, 988, 989
483	541, 542			Tracheostomy w/ mechanical vent 96 hrs+	003, 004
475	565, 566	518.81		Respiratory System diagnosis with ventilator support	207, 208
148	569, 570			MAJOR SMALL & LARGE BOWEL PROCEDURES	330, 331
	79*			Respiratory Infections and Inflammations, Age Greater than 17 with CC	177, 178, 179
	NOTES:			**(*) RAC targeted DRGs with only one secondary diagnosis**	
				RAC identified incorrect selection of Principal diagnosis: Sepsis, septicemia, vs. urosepsis	
				RAC identified incorrect selection of Principal diagnosis: DRG 475 - Respiratory failure 518.81 vs. Sepsis (038-038.9). Other DRG impacted 468.	
				RAC targeted Debridement (excisional vs. nonexcisional)	

Table 2: RAC Top Automated Review Medical Necessity – Hospital Outpatient Procedures

CPT	Description	Units/Modifier
J2505	Neulasta (Pegfilgrastim) 6mg	6mg = 1 unit. Hospitals billed for 6 units instead of 1 unit
36430	Blood Transfusions: Reported only one time per transfusion session regardless of how many units are administered (do not bill in 15 min. increments)	1 unit per transfusion session. Hospitals billed for multiple units
92506, 92507	Speech Therapy Initial Evaluation	Code is per session, bill Only 1 Unit. Hospitals billed in 15 min. increments & multiple units
45355, 45378, 45380, 45383, 45384, 45385	Colonoscopy	Hospitals billed for multiple colonoscopies to the same beneficiary the same day. Can only bill one unit per code per day.

7. Special Areas of Focus

a. One-Day Stays

One-day length of stay Medicare claims were a focus for the RACs during the demonstration program. Many of these admissions were denied based on RAC determinations that the cases were more appropriate for outpatient observation rather than an inpatient admission.

Many of the reports previously mentioned in this chapter, provide an organization with information and comparative data regarding one-day admissions. If one-day admissions are identified, organizations need to assess the medical necessity of those admissions and confirm whether or not the one-day stay was related to a procedure that is identified on the CMS Inpatient-only list (these one day stays would be permissible)[2]. If

[2] Please note: Hospital staff should be familiar with the Medicare Inpatient-only list that is published on an annual basis. It is found in Appendix E of the Hospital Outpatient Prospective Payment System Final Rule each year. Medicare reimburses these cases only when they are billed as inpatient and does not believe these procedures are to be performed on outpatients.

admissions are determined to be medically unnecessary, and would have been more appropriate for outpatient observation, the hospital should take steps to determine why the inpatient admission occurred. Some reasons could be attributed to lack of knowledge, issues with admission orders (Inpatient vs. Observation) and technical concerns.

Hospitals, physicians and case managers might not have up-to-date knowledge about the subject. Assess knowledge regarding the following and provide education as needed:

- Understanding of Medicare rules
- Awareness of utilization review criteria and the Hospital Conditions of Participation related to Utilization Review (42 CFR 482.30)
- Impact on physician reimbursement
- Financial responsibilities of the patient

Organizations also need to assess and monitor the application of admission screening criteria (e.g. InterQual®) by case managers. For example:

- Are the case managers using the most current version of the screening criteria?
- Are case managers applying the criteria correctly?
- Are they applying criteria consistently?
- Are the case managers using the InterQual® inpatient procedures list instead of the Medicare published Inpatient Only procedures list?
- How are "social admissions" handled?

In addition, hospitals need to assess possible issues with physician orders. Assess the following:

- Process for designating patient status on admission
  - Are controls in place to avoid errors?
  - Case Management Assessment Protocol (Florida Protocol)
- Legibility of orders - can staff understand the order?
- Compliance with rules regarding status changes (e.g. Condition Code 44)

Furthermore, hospitals should assess technical controls. Are there controls in place to monitor the following?

- Accuracy related to physician order transcription
- System related errors (hardcoded processes)
- Contractual requirements (e.g., Medicare vs. Medicaid requirements for admissions)

Finally, organizations should establish processes to regularly monitor the data that is generated within and outside the organization. As mentioned previously, areas where one-day admission data might be generated include, but are not limited to the following:

- Routine data monitored or presented by the case management, patient account or finance department related to one-day admissions.
- PEPPER reports
- Denials and appeals data
- HeRMES

b. Three- Day Admission Followed by Discharge to Skilled Nursing Facility

During the RAC demonstration program, the RACs also focused on inpatient claims where the patient appeared to be held in the hospital for three (3) days in order to qualify for Medicare Skilled Nursing Facility (SNF) coverage.

Utilize the tools/information listed in the one-day stay section above to determine if controls need to be put in place to prevent medically unnecessary admissions or continued stays.

8. Conducting the Risk Assessment

The risk assessment approaches include interviews, internal control questionnaires to assess risk factors and controls (see Table 3), and reviews of past audit results. The facility can utilize the enclosed sample questionnaire to prioritize audit efforts to focus on specific departments, business units, processes, transactions, and provider professional services with the potential highest risk.

Please refer to Chapter 3 which describes a legal risk assessment methodology as an additional resource related to customizing your risk assessment process for your organization.

a. Determining the Data Sample and Size

Sampling for RAC audits may vary depending upon the intent of the audit.

- If the primary objective of the audit is to determine, in a non-statistical manner, whether a possible compliance concern exists, a judgmental

- Sample of 20 to 30 claims may be appropriate for a preliminary assessment.

- If the intent of the audit is to determine the error rate and define overall exposure, a statistically valid sample methodology should be employed.

- The types of data/records and time period to be tested are determined based on the purpose of the audit projects and other key factors determined by the Chief Compliance Officer (CCO), the Chief Audit Executive (CAE) and Legal Counsel.

- Data or records may be concurrent (before a claim is submitted for payment), or retrospective (after a claim has been submitted for payment).

- The time period to be tested should allow for submission of corrected claims for errors identified. Typically, retrospective preliminary assessment sample time periods are within the last 30 to 60 days.

- The significance of a valid statistical sample is that the results may be extrapolated over the entire population of transactions. Because of this, it is important that the CCO, CAE, Legal Counsel, process owner and auditor agree on the process upfront. When statistical samples are required, sampling software such as the OIG's "RAT-STATS" (http://www.oig.hhs.gov/organization/OAS/ratstat.html) statistical software should be utilized. Involving Legal Counsel is critical in decisions resulting in statistically valid results, since such results may impact government reporting requirements and related disclosures. (See Chapter 3 of this Manual).

- If problem areas are identified as part of the preliminary assessment, decisions can be made regarding expanding the sample or using computer assisted audit techniques to define the universe of accounts with the potential problem area for additional audits.

Practice Tip

SAMPLE READY-TO-USE DOCUMENTS:

To jump-start your RAC readiness by completing the "Sample Risk Assessment Questionnaire", TABLE 3. Get your RAC readiness on the fast track; download from the GHA website (member hospitals) this helpful ready-to-use tool.

TABLE - 3
Sample RAC Readiness Risk Assessment Questionnaire

Question	yes	no	Comments
RAC Process			
1. Have you assembled a RAC team?			
2. Is there a documented process to track and log all RAC requests?			
3. Is there a process for monitoring and assembling resources for photocopying charts?			
4. How do you review the RAC's audit responses?			
5. Is there a process to determine when/when not to appeal?			
6. How are you keeping track of what you appeal?			
7. How are you tracking the financial effect of RAC related changes?			
8. How are you examining DRG pairs to identify areas, such as sepsis, where you are falling outside the norm?			
9. Do you have a documentation improvement program developed to rapidly respond when areas of improvement are noticed?			
10. How are records reviewed before sending to RAC?			
11. What process is in place to take and track corrective action?			
12. Is there a proactive process to review vulnerabilities in areas such as chargemaster, charge capture, and observation versus inpatient?			
13. If you have a fragmented medical record, how is this addressed?			
Physician Process			
14. If a case does not meet inpatient screening criteria, how do you conduct second-level physician review to obtain a correct determination of the inpatient/outpatient decision?			
15. Is there communication between the physician making the secondary physician review determination and the treating physician?			
16. Does the chart documentation reflect the secondary physician review determination and process?			
17. Is there a process to ensure that the treating physician, hospital and beneficiary are aware of the final claim status (observation versus inpatient) before patient discharge?			
Nursing Process			
18. How does nursing determine how to chart for recovery time, observation time and inpatient time?			
19. If a claim contains an observation and an outpatient procedure code, how do you determine if the observation hours were actually postprocedure recovery?			
20. Do nurses understand the different codes for drug administration?			
Utilization Review Process			
21. Are case managers proficient and appropriately trained regarding clinical criteria and documented policies/procedures?			

22. Is screening occurring according to requirements?			
23. Are all patients being reviewed by case management with no missed admissions?			
24. How are admission review results documented in an auditable fashion?			
Focus Area - Observation			
25. How do you verify that the physician's order for admission to observation status and the order for discharge from observation status were dated, time-stamped and signed?			
26. Do nurses notes reflect the date and time the patient was admitted to the observation bed and the date and time the patient was discharged?			
27. Did the physician document an assessment that determined the beneficiary would benefit from observation services?			
28. Do the nurses notes address the reasons for observation stay?			
29. Do procedure notes and/or operative notes address complications that support admission to observation status?			
30. Is there a process to keep track of non-billable observation hours and perform root cause analysis?			
Focus Area - Short Stays			
31. Is a process in place for case managers to review all patient admissions against observation and inpatient screening criteria (e.g. InterQual®, Milliman) to ensure appropriate status assignment?			
32. What is the availability of case management to conduct this screening for short stays?			
33. Is there a process to have a physician review cases that fail to meet screening criteria?			
34. Do you have a physician advisor, trained in the regulations who can communicate with treating physicians?			
35. Is there a system to clarify unclear admission orders prior to admission?			
36. How do case managers use screening criteria to determine medical necessity? Do they utilize an automated program? Is it a manual process?			
Focus Area - Condition Code 44			
37. Is there a documented process for changing patient status and use of Condition Code 44?			
Focus Area - PEPPER Reports			
38. Is there a documented approach to review PEPPER reports?			
39. How are findings from analysis of PEPPER reports communicated? Which internal committee provides oversight and monitoring for this area?			

CHAPTER 3:

CONDUCTING AN INTERNAL LEGAL RISK ASSESSMENT

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1. Why conduct an Internal Risk Assessment

The implementation of the RAC program provides another important justification for a careful and systematic program for conducting internal assessments of compliance risks. If a provider discovers its problems first, it can reduce its legal exposure and maintain a compliant enterprise. Early detection of potential criminal behavior can place a hospital in a position to take advantage of immunity and leniency programs and sentencing guideline incentives. A hospital may also be able to avoid regulatory exposure and additional civil penalties by adopting a program of well-planned, periodic risk assessments.

Sometimes however, providers are driven to a risk assessment due to allegations of misconduct, a government inquiry, or a contractor's audit. In cases of inquiries initiated by the government or its contractors, conducting a concurrent internal investigation in a manner that preserves the organization's legal rights and privileges while the government or contractor performs its investigative works is often beneficial. If a provider is aware of a government inquiry or concern but fails to conduct an internal investigation, the provider places itself in a defensive position. The failure to conduct an internal investigation will likely raise issues regarding the provider's actual knowledge, deliberate ignorance or reckless disregard of misconduct, which could increase legal exposure for the provider. An internal investigation provides the opportunity for the organization to assess its practices and, where necessary, have greater control over any needed corrective action.

2. Steps for conducting an Internal Risk Assessment

a. Identify the Purpose/Goal of Risk Assessment

The single most important organizational step in conducting an effective internal risk assessment is developing a mission statement including objectives to be achieved and a specific definition of the issues to be investigated. The provider should develop short and long term plans for using the information that will be gathered. The mission statement should be used as the blueprint in how the provider designs its risk assessment. A provider should also consider whether the assessment will focus solely on allegations of wrongdoing or noncompliance, or whether the purpose of the review is to assess general organizational risks.

b. Identify the Scope of the Assessment

In determining the scope of the risk assessment a provider should, first and foremost, identify the risk universe. A provider should review records regarding litigation, hotline or helpdesk reports, internal and external complaints, audit reports, and other available records likely to include relevant information regarding potential risks. It will also be beneficial to search public records and news reports for any compliance risks that competitors may have encountered and review OIG guidance and work plans for risk

areas. Talking to lawyers, auditors, risk managers, human resources managers, and others in a position to see day-to-day operations can also help identify the risk universe.

A provider should then identify its available resources. This is critical in determining the risk assessment scope. Management should honestly consider whether it has the resources to conduct adequate and meaningful risk assessments. It is recommended that providers prioritize allegations and issues and allocate necessary resources to those issues that are more serious. It may be helpful to organize identified risks in some form of hierarchy that can be adjusted as new risks are identified in the future. A provider should seriously invest the time to develop a detailed and realistic plan.

The specific issue or allegation involved will usually determine the overall scope of the assessment. Prevalent and systematic allegations require a broader approach than isolated issues and may require system testing or sampling techniques. Other factors to consider in determining the scope of the assessment include, the number of persons involved, the number of departments or entities involved, whether mid-level, senior management or Board members are involved (or disregarded previous allegations), the period of time involved, whether there are allegations that conduct violated the provider's compliance program, the likelihood of a civil/qui tam action, and the likelihood of adverse publicity.

c. Identify the Investigative Team

In organizing an investigative team, a provider can employ outside consultants or experts or utilize in-house persons, such as the compliance officer, general counselor, CFO, Chair of Audit Committee, or other leaders within the organization.

i. Use of Outside Consultants:

A provider may find it advantageous to employ outside consultants to assist in conducting an internal risk assessment for several reasons. One benefit of employing outside consultants is that they are generally viewed as independent by government authorities. In addition, the investigation may be conducted more quickly due to the dedicated outside resources and the expertise of outside consultants. Aside from the benefits of employing outside consultants, there are a few drawbacks that should be taken into account. An outside firm or consultant will likely be more expensive than internal resources, and an outside firm is less familiar with the provider's operations or employees, and care must be taken to avoid apprehension among the provider's staff.

The organization should strongly consider conducting internal reviews potentially involving improper claims submission or regulatory non-compliance in a manner that preserves the legal privileges of the organization. See Section 2. (d). Under these circumstances, outside consultants or experts should be engaged by the organization's attorney and conduct their assessment at the direction of an attorney. An engagement letter should be prepared by the attorney directing the investigation setting forth clearly

the scope of the consultant's engagement. All reports and opinions regarding the investigation developed by outside experts should be made only to the attorney engaging the consultant or expert to protect legal privileges.

If a written report is rendered by the consultant, the organization should be mindful that such a report could be required to be provided to the government in the event of a government investigation if the report is not protected by the organization's legal privileges, such as the attorney-client privilege and the attorney work product doctrine. Organizations should make sure the report's recommendations are carefully considered by management in departments relevant to the investigation and by the organization's governing boards or committees where appropriate.

ii. Compliance Officer's Involvement

A provider can also utilize its internal compliance officer to conduct the internal risk assessment. The advantages and disadvantages associated with using in-house personnel practically mirror the pros and cons associated with the use of outside consultants. The notable advantages in utilizing the compliance officer include the fact that he or she is likely familiar with employees who may be interviewed and the everyday operations of the provider's business. The compliance officer would likely be less expensive than retaining an outside expert and also less likely to disrupt operations. There are some drawbacks that should be taken into consideration here as well. The compliance officer is likely to be part of the organizational team responsible for assessing the results of the internal review. As a result, having independence from the investigation allows the compliance officer to assess the results objectively and critically and develop a responsible plan of action. An internal risk assessment or investigation can create institutional tension, which could last after the assessment is complete. Having the compliance officer in the position of a neutral may be desirable as a long-term institutional objective. Realistically, depending on the size and resources of the provider, the compliance officer and in-house personnel may not be able to adequately conduct an assessment in light of their other duties. In any event, the compliance officer should be involved in defining the mission of the internal review, the team to be used, and the assessment of results.

If provider decides to handle the risk assessment internally, the compliance officer can conduct the investigation, or delegate the investigation to other in-house personnel, including legal counsel. It is important that no one involved in any alleged misconduct be allowed to participate in conducting the investigation. If the compliance officer chooses to delegate the responsibility of the assessment, the compliance officer should provide direction on the scope and purpose of assessment. In turn, the in-house personnel should report their findings directly to the compliance officer.

iii. Reporting Structure

Once the investigating team is determined, the provider should establish formal lines of supervision and reporting. Whether the investigation is being conducted by

internal or external personnel, a point person at the provider should be established to monitor the status of the investigation. Depending on the seriousness of the inquiry, results of the risk assessment may be reported to the compliance and/or audit committee or directly to the board. The provider should make sure all individuals affected by the risk assessment are made aware of its results and any corrective action that is recommended.

d. Consider Legal Privileges

i. Should the assessment be done under legal privileges?

1. Attorney Client Privilege

Under the attorney client privilege, all communication between an attorney and a client made for the purpose of obtaining or giving legal advice are confidential. The purpose of the attorney client privilege is to encourage full and frank communication between attorneys and their clients. The privilege recognizes that sound legal advice depends upon lawyers being fully informed by their client. The attorney client privilege is held by the client, not the attorney. Thus, if the client decides to disclose the communication, the client can do so without the attorney's approval.

Complications in the application of the privilege may arise when the client, such as a health care provider, is a company or corporation and not an individual. In the health care provider context, the privilege generally exists when the communication is made by employees of the provider client to counsel at the direction of superiors in order to obtain legal advice from counsel for the provider. Attorney's notes and interview summaries, to the extent these materials quote, contain or reflect communication to or from employees of the provider are protected by the attorney client privilege.

In order to preserve this privilege when communicating with provider's employees, the attorney for the provider should make it clear that they represent the company, not the employee. Each employee interviewed should be made aware that the interview is being conducted at the request of corporate superiors and that the attorney conducting the interview is doing so in order to provide legal advice to the company. Employees should be aware that the attorney-client privilege belongs to the company, which can be waived by the company's management or governing board. If the privilege is waived, the contents of the interview may be disclosed. Providers should keep in mind that the possibility exists that the government may request a waiver of the attorney client privilege during the course of a government investigation.

2. Work Product Privilege

The work product privilege is narrower than the attorney client privilege and only protects documentation and mental impressions prepared in anticipation of litigation. The work product privilege provides qualified protection to documents prepared in anticipation of litigation or for trial by or for a party, or by or for a party's

representative.[1] Opinions, conclusions, legal theories, mental impressions, etc. of an attorney or other representative are also protected under the privilege. This privilege is held by both the client and the attorney.

For an opposing party to obtain disclosure of protected work product, it must demonstrate a substantial need of the materials to prepare its case and an inability, without undue hardship, to obtain the substantial equivalent of the materials by other means.[2] Documents containing the mental impressions, conclusions, opinions, or other legal theories of an attorney or other representative of a party, concerning the litigation are, absolutely protected.[3] The discovery protection under the work-product privilege extends to a party and his representatives in addition to the party's attorney.

Whether documents were prepared in anticipation of litigation depend on the nature of the claim and the type of information sought and, therefore, turns on the facts of each case. A document may be considered to have been prepared in anticipation of litigation if the litigation that caused its preparation was an investigation by a government agency, and not a traditional civil suit. Because litigation is a foreseeable result of a government investigation, the investigation represents more than a remote possibility of future litigation, and provides reasonable grounds for anticipating litigation.

The Department of Justice and Congress have set forth special guidelines on the use of both the attorney client and the work product privileges in the context of corporate investigations. The "Thompson Memo," a memorandum issued by former Deputy Attorney General Larry Thompson in January of 2003, sets out factors that the Department of Justice will use to decide if a business organization should be charged with a crime. According to the Thompson Memo, a fact to be considered in evaluating whether to charge a corporation is the timely and voluntary disclosure of wrongdoing and a company's overall willingness to cooperate with government investigations. Cooperation by a company can be demonstrated by the company's willingness to identify the culprits (including senior executives), make witnesses available, disclose internal investigation reports, and specifically waive the attorney client and work product privileges. The McNulty Memo, a subsequent memorandum issued by United States Deputy Attorney General, Paul J. McNulty, in 2006, and revisions to the Federal Sentencing Guidelines have sought to reduce the impact of the Thompson Memo and the erosion of a company's evidentiary privileges. The McNulty Memorandum was further clarified by the July 9, 2008 letter to United States Senate Committee on the Judiciary from Deputy Attorney General Mark Filip. The Filip letter stated that the Department of Justice will not consider whether the corporation has waived legal privileges in determining whether an organization has "cooperated" with authorities, but will instead assess whether the organization has "disclosed relevant facts and evidence." Likewise, the Filip letter states that it will not consider whether the organization advanced attorney's fees to its employees or officers or entered joint defense agreements in determining "cooperation." However, it should be noted that companies may still be

[1] *See* Fed. R. Civ. P. 26(b)(3).
[2] *Id.*
[3] *Id.*

granted cooperation credit for "voluntarily" waiving privilege when necessary to convey "relevant facts and evidence" to the government. The important point here is that the waiver of privilege should be a matter a choice – not a matter of compulsion due to an inadvertent waiver of the confidential nature of an assessment or investigation.

ii. Steps to Protect Legal Privileges

1. Counsel must direct investigation

In order for an evidentiary privilege to attach to an internal risk assessment or investigation, it is necessary that counsel direct the investigation.

a. Internal v. External Counsel

The protection of privileges can be more difficult where in-house counsel is responsible for conducting the risk assessment. The in-house counsel's role as legal and business advisor, coupled with the close connection that in-house counsel generally share with management, make the attorney client privilege susceptible to attack. In addition, when in-house personnel conduct an investigation, concerns regarding the independence of the investigation may arise. Internal counsel should not direct any investigation into matters relating to the legal advice previously furnished by that attorney. In addition to raising questions of independence, if management asserts an advice-of-counsel defense on behalf of the company, the attorney-client privilege is waived and the communication between the attorney and the client is discoverable.

When internal legal counsel is used to conduct a risk assessment, it is important to document that counsel is acting as a lawyer to the organization in connection with the investigation. Counsel should segregate documents relating to the investigation and related legal matters from records relating to business advice. Documents created as part of the in-house attorney's legal work relating to the internal investigation should bear a legend reflecting the document's legally privileged character (e.g "Subject to Attorney Client Privilege" or "Subject to Attorney Work Product Doctrine"). Privileged documents and investigative materials should be segregated from other business files and should be secured in a manner which protects the confidentiality of their contents. The mission statement for the internal risk assessment should identify in-house counsel as participating in his or her role as an attorney and state that counsel is gathering information or directing others to do so in order to render legal advice to counsel's organizational client. The scope of the "engagement" of in-house counsel in connection with the investigation should be clearly defined. In this way, the mission statement for the internal review will help protect the legal privileges of the organization if the assertion of privilege is challenged. Moreover, if the scope of the investigation or the role of in-house counsel changes during the investigation in reaction to information or developments, the mission statement should be updated to reflect the evolving responsibilities of counsel.

2. Engagement Letter

To enlist the assistance of an outside attorney or law firm, it is necessary that a provider memorialize its request for legal advice in an engagement letter. In order to protect the attorney client privilege, the engagement letter should be sent to counsel by top level management and should make explicit that the purpose of the investigation is to enable the attorney to provide legal advice to the provider. The engagement letter should also give counsel the authority to conduct interviews with employees of the provider in order to gather information needed to render sound legal advice to the company. In addition, the letter should make clear that the nature of the investigation is confidential as well as information received from employees as a result of the investigation.[4]

If an investigation is to be conducted by in-house counsel, the investigation should be conducted with clear direction by top-ranking management officials. This direction should make clear the nature and scope of the investigation and indicate that the purpose of the investigation is to render legal advice to the organization.

3. Handling Documents/Communication

To preserve privilege, it is necessary that a provider limit the access to privileged communications and documents. Most of the investigation or assessment should be handled by attorneys. The attorneys should mark all documents as privileged, keep privileged documents and communications separate from non-privileged documents, and keep the communication within the highest level of the organization. If privileged communication or documents need to be reviewed by non-attorneys, the attorney should seek return of documents. Companies should request that employees providing key information report directly to the attorney – not through the regular chain of command.

iii. Peer Review Issues/Self Evaluative Privileges

Georgia recognizes a medical peer review privilege. The purpose of the privilege is to foster the candor necessary for effective peer review essential in providing quality health care services and ensure regulatory compliance.[5] The privilege '"places an absolute embargo upon the discovery and use of all proceedings, records, findings and recommendations of peer review groups and medical review committees in civil litigation."' [6] However, the prohibition on the discovery of peer review materials is not unlimited. The statute precludes a party from discovering the proceedings and records of a peer review organization, but it specifically authorizes a party to seek documents from the original sources on which the peer review organization examined issues. [7]

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[4] *See Upjohn Co. v. United States*, 449 U.S. 383 (1981).
[5] *See* O.C.G.A. § 31-7-133(a).
[6] *Ussery v. Children's Healthcare of Atlanta, Inc*., 289 Ga. App. 255, 268, 656 S.E.2d 882,893 (2008) (citing *Freeman v. Piedmont Hosp.*, 264 Ga. 343, 344, 444 S.E.2d 796 (1994)).
[7] *Id.* at 268, 656.

The peer review privilege may have little application in federal cases. In a recent Eleventh Circuit case, *Adkins v. Christie*, the Court failed to apply the peer review privilege to federal civil rights cases.[8] The Court noted that privileges, such as the peer review privilege, are disfavored in federal courts and are generally unwarranted absent a situation where recognizing the privilege would achieve "a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth." [9]

Similarly, the self-critical analysis privilege is an evidentiary privilege that was originally designed to protect documents produced during peer review committee meetings in a medical malpractice action. It has evolved into a privilege protecting certain self- evaluations undertaken by organizations to determine their compliance with regulatory requirements. Thus, the underlying policy reasons supporting the self-critical analysis privilege reflects those of the medical peer-review privilege: to encourage an organization's compliance with laws that are aimed at protecting the health, safety, and welfare of all. [10]

It is unsettled, however, whether Georgia courts acknowledge the self-critical analysis privilege, particularly in instances where the material is sought by the government. Some courts have acknowledged the viability of the privilege when sought by non-governmental parties and in instances where the privilege was asserted to protect self-evaluative documents submitted to government agencies for compliance purposes.[11] Courts have reasoned that the protection of such documents was necessary because public interest is furthered when corporations or organizations seek to analyze safety or compliance with certain laws.[12] It must be noted however, that Georgia state courts or Georgia legislature have not explicitly recognized this privilege. At least one court has declined to read the privilege into Georgia law, absent an explicit adoption.[13] Communication and documents that fall squarely within the peer review function are statutorily protected under Georgia law. Other documents, however, which may fall outside the realm of "peer-review" but serve other self-evaluative functions, may not be protected under the self-critical analysis privilege. As a safeguard, follow necessary procedures (to the extent possible) to protect this communication under the attorney client or work product privileges when conducting an internal risk assessment.

3. Methodology for Risk Assessment

a. Document Collection/Preservation

The identification and collection of relevant documents is often the first step in an internal risk assessment or investigation. Preserving relevant documents is critical to the process, whether the documents be physical or electronic records. Provider should be

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[8] See *Adkins v. Christie*, 488 F.3d 1324 (11th Cir. 2007).
[9] *Id.* at 1328.
[10] *Lara v. Tri-State Drilling, Inc*., 504 F. Supp. 2d 1323 (N.D. Ga. 2007).
[11] *Id*. See *Shipes v. BIC Corp*, 154 F.R.D. 301 (M.D.Ga. 1994); *See also Joiner v. Hercules*, 169 F.R.D. 695 (S.D.Ga. 1996).
[12] *Id*.
[13] *Lara*, 504 F. Supp. 2d 1323.

mindful that destruction of documents with knowledge of wrongdoing or in light of government investigations creates a serious risk of obstruction of justice exposure in cases of suspected wrongdoing.

The investigation team should familiarize itself with how provider stores its records, computer or otherwise. The investigation team should coordinate with provider's information technology staff to ensure relevant electronic documents are preserved, which may include halting the destruction/recycling of backup tapes.

In a government investigation or administrative auditor inquiry, a written memorandum should be provided at the earliest possible time to all employees who may have information relevant to the investigation. This document should clearly describe the nature of the investigation and documents that must be preserved. In addition to fact witnesses, the document retention memorandum should be distributed to personnel responsible for the destruction of paper and electronic records. The document retention memorandum should identify a member of the investigation team who will serve as point person for collecting responsive materials and who can answer any questions employees may have about which documents should be preserved.

Investigative materials should be collected and segregated in a secure location.

b. Witness Interviews

One of the first steps in conducting a risk assessment is to interview all of the key witnesses. The purpose of the witness interviews is to identify the key facts, the critical documents, and other important witnesses. Employees have a duty to cooperate and be interviewed absent a contractual provision to the contrary.

These interviews may be conducted by in-house or outside counsel or their designated investigators under the attorney client privilege. If the interviews are to be conducted by attorneys, it is essential that all of the steps outlined in section 2.(d) (ii) above be taken to protect the attorney client privilege. The employee should be clearly advised that the attorney represents the provider, not the employee, that the conversation is privileged, and that the employee should keep the conversation confidential to avoid a waiver of the privilege.

Witness interviews should be conducted individually, not in a group setting. The interviewer should provide the employee with a brief description of the nature of the investigation and the purpose of the interview. The subjects of the interview should be identified by the investigative team in advance and decisions should be made about the case of relevant documents in the interview. The interviewer should be careful in crafting the interview questions and explaining the nature of the investigation not to unduly influence the interviewee's answers.

As soon as possible after the interview, the interviewer should prepare a summary of the interview. The summary will become part of the investigation file and should be

distributed only to key personnel involved in conducting the investigation. The summary may contain attorney client privileged communications and attorney mental impressions and should be kept confidential. If the interview was conducted under the attorney client privilege, the summary should be prepared by counsel and clearly labeled: "Privileged and Confidential, Subject to Attorney-Client Privilege and Attorney Work Product Doctrines."

c. Consider use of Statistical Sampling

The investigation team may use statistical extrapolation from random samples to establish the scope of the problem and determine if any refund is due the government for overpayment. Statistical sampling may be used in circumstances where it is impractical to do a claim by claim review. This determination should be based on the size of the population believed to be involved, the time period during which the issue is believed to have occurred, and the resources needed to conduct the assessment.

There are two distinct uses for sampling methodologies: issue identification and quantification. Sampling for issue identification is often an effective tool. The use of so-called "probe samples" involve the selection of a limited number of claims for analysis of potential billing or compliance issues or systemic weaknesses. The benefit of a probe sample, which is generally too small to be used for a reliable statistical quantification of the financial impact of a type of error, is that it can assist in identifying the types of errors that the investigation may need to consider and thus assist in the development of an investigative plan. A "statistically valid sample" is generally employed to quantify the impact of an error within a defined statistical tolerance. Such a sample is generally employed after the errors have been identified and their causes factually investigated. Careful consideration should be given to the use of any sampling method, and the organization should strongly consider the use of a consultant for the purpose of developing a sampling method. In addition, sampling analyses should be directed by counsel in order to preserve the privileged character of the results when those results are needed for rendering of legal advice to the organization.

In the event the provider is considering the use of statistical sampling results as part of a disclosure to the government or for the quantification of a repayment to a payor, the provider will need to be able to clearly explain and justify the methodology used in selecting the random sample and in conducting the extrapolation.

4. Self-Disclosure Concerns

After the investigation is concluded, provider must decide what to do with the results. If an overpayment is identified, provider should consider whether self-disclosure is appropriate and if so, which government agency it should make the disclosure to.

a. Disclosure to the Medicare Contractor

All providers with effective compliance programs will routinely identify billing errors and overpayments. For these routine cases, disclosures should be submitted

directly to the Medicare Contractor. Providers should be mindful that matters that potentially involve fraud – meaning matters that potentially violate federal criminal or civil law or administrative laws for which exclusion or civil monetary penalties apply – are more appropriately addressed under the OIG Provider Self-Disclosure Protocol or directly with government attorneys. Moreover, Medicare Contractors are directed to forward disclosures of potential acts of fraud and abuse to OIG for review.

b. Disclosures under the OIG Provider Self-Disclosure Protocol

The Office of Inspector General (OIG) Provider Self-Disclosure Protocol encourages providers to voluntarily self-disclose evidence of potential fraud. The premise of the Self-Disclosure Protocol is that health care providers must be willing to police themselves and work with the government to combat healthcare fraud.

The Self-Disclosure Protocol should only be used in cases where it appears a potential fraud has occurred. A recent Open Letter to Health Care Providers makes clear that the Provider Self-Disclosure Protocol is only to be used for matters that potentially violate Federal criminal law, civil law, or administrative laws for which exclusion or civil monetary penalties are authorized.[14] The Provider Self-Disclosure Protocol should not be used in cases of mere billing errors or overpayments.

When making a self-disclosure, the provider should refer to the Provider Self-Disclosure Protocol and submit all of the requested information.[15] Every self-disclosure should include the following basic information: (1) the Review Objective, (2) Review Population; (3) Sources of Data; and (4) Qualification of Personnel involved in the assessment. In addition to that basic information, recent guidance from OIG suggests that the initial submission should also include: (1) a complete description of the conduct being disclosed; (2) a description of the provider's internal investigation or a commitment regarding when it will be completed; (3) an estimate of the damages to the Federal health care programs and the methodology used to calculate that figure or a commitment regarding when an estimate will be complete; and (4) a statement of the laws potentially violated by the conduct. At the time of the self-disclosure, the provider must be in a position to complete the investigation and damages assessment within three months after acceptance into the Provider Self-Disclosure Protocol.

Making a self-disclosure following the terms of the Provider Self-Disclosure Protocol may indicate to OIG that provider has an effective compliance program. Accordingly, OIG generally does not require providers to enter into a Corporate Integrity Agreement or Certification of Compliance Agreement following a self-disclosure.

c. Disclosures to the Department of Justice

In the event an overpayment is identified during the course of an ongoing government investigation, provider should consider making a disclosure directly to the

[14] An Open Letter to Health Care Providers, April 15, 2008.
[15] 63 Fed. Reg. 58, 399 (Oct. 30, 1998).

Department of Justice. This is particularly true if the overpayment is related in any way to the scope of the government's investigation. The provider, through its attorneys, can then work with DOJ to determine the appropriate mechanism for addressing the overpayment. Making a self-disclosure to DOJ during an investigation can help demonstrate that provider has an effective compliance program and that provider is dedicated to addressing any identified problems.

d. Disclosures to State Officials

Provider may also need to make a disclosure to state officials if the Medicaid program is impacted. Disclosures directly to the Medicaid program should be for routine billing errors and overpayments; suspected fraudulent activity should be disclosed as provided in Section b. above.

e. Other Disclosures

Provider's risk assessment may also identify overpayments or billing errors that impact reimbursement from private payors. In such case, provider should consult its contract with each payor and follow the procedure outlined for making a self-disclosure. Provider may need to work with the private payors to determine whether a refund of any co-payments by individual patients is necessary as well.

5. Government Investigations and Federal and State FCAs

a. Statutory Overview

The False Claims Act ("FCA") was enacted in 1863 to combat fraud on the federal treasury.[16] "Any person who knowingly presents or causes to be presented, to an officer or employee of the U.S. Government…a false or fraudulent claim for payment or approval…is liable to the U.S. Government."[17] Under § 3729(c), a "'claim' includes any request or demand … which is made to a contractor, grantee or other recipient if the U.S. Government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of money or property which is requested or demanded." Congress intended for this language to codify federal decisions extending the reach of the FCA to fraud on the Medicare program through claims submitted to, and paid by private intermediaries[18], such as insurance companies and to codify federal decisions extending the reach of the FCA to fraud on the Medicaid program through claims submitted to the States, which receive federal funding and are subject to extensive federal regulations.[19] Many jurisdictions, including Georgia, now have state False Claims Acts as well. The Georgia False Claims Act essentially mirrors the Federal FCA and allows the state to directly pursue false claims made on the Medicaid program.

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[16] 31 U.S.C. §§ 3729 – 3733.
[17] 31 U.S.C. § 3729(a)(1).
[18] *Peterson v. Weinberger*, 508 F.2d 45 (5th Cir. 1975), *cert. denied*, 423 U.S. 830 (1975).
[19] *United States ex rel. Davis v. Long's Drugs, Inc.*, 411 F.Supp. 1144, 1146-47 (S.D. Cal. 1976).

b. Commencing the Investigation

FCA cases arise in different ways. In some instances, the government brings the case directly. This may be the result of recent enforcement initiatives, data mining, or reports by a whistleblower. In other instances, a *qui tam* relator, a private plaintiff, may bring the case on behalf on the U.S. government. In such case, the federal government will have the opportunity to intervene and assume control of the case or decline to intervene, leaving the further pursuit of the case to the relator.

c. *"Whistleblower" Activities and Under Seal Complaints*

To initiate an FCA case, a *qui tam* relator serves a copy of the complaint, and substantially all material evidence on the federal government. § 3730 (b)(2). The *Qui tam* relator files the complaint in camera under seal. *Id*. The complaint remains under seal for at least 60 days and often for longer (although within the court's discretion) and remains concealed from the defendant, until the court orders it served. *Id*. This occurs after the government has made a decision on whether or not to intervene in the case. In some cases, the government may request that the court partially lift the seal to allow all of the complaint to be shared with a defendant to further settlement discussions.

d. Requests for Information

Confirmation that a government investigation is underway often comes through a formal request for information from the government, when provider is served with a subpoena. Immediately upon receipt of a subpoena, provider should issue a document retention memorandum (see section 3. (c) above) and take steps to ensure all relevant materials are preserved if it has not already done so.

The provider should cooperate with the government by producing the requested materials in a timely manner. Provider's counsel may be able to negotiate the terms and scope of production with the government to minimize the burden and expense on the request. Requests for electronic files and communications are especially complicated and may require a targeted search of databases. In such cases, some discussion with the government concerning the methodology to be utilized in identifying relevant data is recommended. In the event of an impasse, judicial review may be required.

e. Interview Requests and CIDs

The government may also request interviews of a provider's employees. The provider should consider whether its own outside counsel should represent its employees or if the employees should be provided their own, independent counsel. For this reason, while the provider may decide to encourage an employee's cooperation, each employee will ultimately decide whether to comply with an informal government request for an interview. In cases where there is a reasonable likelihood that provider's interests may diverge with that of an employee, individual counsel is recommended.

Often requests for employee interviews are made informally, but the government may also utilize Civil Investigative Demands ("CIDs") to gain information. CIDs provide the civil division of the U.S. Attorney's office the authority to compel the production of documents, deposition testimony, and written responses to interrogatories (written questions). CIDs must be issued and signed by the Attorney General and therefore are not utilized in many cases.

f. Intervention and Litigation

If a *qui tam* suit is filed, the government must either intervene or notify the court within the 60 days (or later if the court extends the period, which is common) if it declines to intervene, and permit the *qui tam* relator to proceed. § 3730 (b)(4)(A)-(B). Defendant has 20 days to answer from the date on which the complaint is unsealed and served. § 3730 (b)(3).

Once the *qui tam* complaint is unsealed, the case proceeds like any other civil lawsuit. The first phase is the discovery period during which both sides may request documents, propound written questions or interrogatories, and take depositions. Unlike a government investigation which generally involves a one-sided production of evidence from provider to the government, the provider is able to obtain information, documents, and testimony through compulsory process from the government, the *qui tam* relator, or third parties. The case may ultimately be resolved through motions on the law or the merits or may proceed to trial.

g. Negotiations and Settlement

Often government investigations are resolved through negotiations and settlement. This has the benefit of allowing provider to control its destiny and reduce its risk of exposure at a trial. Settlement also saves the time, expense, and publicity associated with a trial.

In addition to reaching agreement on the amount to be repaid to the government, provider may also be able to negotiate the terms of any Corporate Integrity Agreement or Certification of Compliance Agreement that the OIG may require be put in place. Provider's cooperation during the investigation and the effectiveness of provider's compliance program will be factors taken into consideration during settlement negotiations.

CHAPTER 4:

DOCUMENTING MEDICAL NECESSITY

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1. INTRODUCTION

The information garnered from the RAC pilot programs in California, Florida and New York revealed that a majority of overpayments recovered from providers in these states stemmed from determinations that the services billed were not medically necessary.[1] Indeed, 32 percent of the denials from the pilot program were based on lack of medical necessity.[2] Another nine percent were denied on the basis of no or insufficient documentation, which can also implicate medical necessity issues.[3] The Centers for Medicare and Medicaid Services ("CMS") has developed a myriad of rules specifying medical necessity for items and services for which Medicare will or will not make payment, either for all beneficiaries or for beneficiaries in specific circumstances. Many of these rules are not found in the Medicare statute and regulations, but are set out in program manuals or guidelines published by local contractors. This chapter outlines the standards for making medical necessity determinations and provides some guidance that may be helpful in the event a claim is denied.

2. THE LEGAL STANDARD OF MEDICAL NECESSITY

As a threshold matter, medical necessity is usually defined very broadly. Generally, an item or service is covered by Medicare if it (1) falls within a Medicare benefit category; (2) is not statutorily excluded; and (3) is reasonable and necessary**.** Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[4] Although the statute generally discusses coverage of broad categories, some items and services are set forth with particularity.[5] Medicare specifically excludes various services from coverage, including routine physical checkups, regular eyeglasses, or hearing aids.[6] It also does not cover custodial care, cosmetic surgery, or routine dental care.[7]

There is no formal or rigid test for determining what is reasonable and necessary. Indeed, what may be reasonable and necessary for one beneficiary may not be reasonable and necessary for another depending on the circumstances. According to CMS's Program Integrity Manual an item or service is "reasonable and necessary" if it is:

- Safe and effective;

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[1] CMS RAC Status Document at http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf Report
[2] *Id.*
[3] *Id.*
[4] 42 U.S.C. §§1395 *et. seq*.
[5] See 42 U.S.C. §§1395x, 1395y.
[6] 42 U.S.C. §1395y(a)(7).
[7] 42 U.S.C. §§1395y(a)(9), (10), (12)

- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD [National Coverage Determination] are considered reasonable and necessary); and

- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

  i. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;

  ii. Furnished in a setting appropriate to the patient's medical needs and condition;

  iii. Ordered and furnished by qualified personnel;

  iv. One that meets, but does not exceed, the patient's medical need; and

  v. At least as beneficial as an existing and available medically appropriate alternative.[8]

Additionally, the American Medical Association provides the following definition for determining whether services are medically necessary:

> Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.[9]

As stated above, not every service is reasonable and necessary for every beneficiary. Because so many varied conditions and variables factor into a provider's decision, what is reasonable and necessary for one beneficiary may not be for another.

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[8] CMS Pub. 100-8, Chapter 13, Section 13.5.1; http://www.cms.hhs.gov/Manuals/IOM/list.asp.
[9] *See* American Medical Association's Model Managed Care Contract at www.ama-assn.org/ama1/pub/upload/mm/368/mmcc_4th_ed.pdf.

Therefore, the completeness of the medical record is key in demonstrating the necessity of the service provided.

Further, courts have shed little light on the meaning of "reasonable and necessary." The limited authority on this point reveals that, to be covered by Medicare, a service or device must be "safe, demonstrated as effective, generally accepted in the medical community, and appropriate." Estate of Aitken v. Shalala, 986 F. Supp. 57, 59 (D. Mass. 1997) (citing Criteria and Procedures for Making Medical Services Coverage Decisions that Relate to Health Care Technology, 54 Fed. Reg. 4302, 4307-8) (Jan. 30, 1989); see also Rush v. Parham, 625 F.2d 1150, 1156 n.11 (5th Cir. 1980) (omitting citations) (stating "a basic consideration is whether the service has come to be generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is being used.") See, Arruejo v. Thompson reprinted in Medicare & Medicaid Guide (CCH) (¶ 301,159)) (E.D.N.Y. 2001). Thus, the standard of review that should be applied is whether the treatment provided was reasonable or necessary in caring for the beneficiary.

Given this broad and relatively vague standard, it is critical that the medical records include sufficient information for a RAC reviewer to conclude that services are covered. Because there are so many variations in patients' histories and treatments, it may be that documentation that supports a favorable coverage determination for a particular patient will not result in the same finding for another individual. For instance, an inpatient admission for a person who presents to the emergency room with symptoms of a heart attack can be reasonable if that person's history of prior heart attack is included in the medical records reviewed. If that prior information is missing, illegible or not readily found, however, a RAC reviewer may decide that the patient should have been placed in observation instead.

The Treating Physician Rule

Because there is such variation among individual patients, it is imperative that the treating physician's documentation be presented in a complete and logical manner. This is important because the RACs should defer to the judgment of the treating physician in analyzing the need for services.

Indeed, courts have found that in accordance with the "treating physician rule," the treating physician's opinion on the diagnosis, nature and degree of impairment and treatment is: (1) binding on the fact finder unless contradicted by substantial evidence; and (2) entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a beneficiary's medical condition than are other sources. Schisler v Bowen, 851 F.2d 43 (2nd Cir. 1998). *See also*, State of New York v. Sullivan, 927 F.2d 57 (2nd Cir. 1991); Pfalzgraf v. Shalala, 997 F.Supp. 360 (WDNY 1998); see also Smith o/b/o McDonald v. Shalala, 855 F.Supp. 658 (D. Vt. 1994) ("the Secretary is expected to place significant reliance on the informed opinion of a treating physician"). Therefore, in documenting medical necessity

of services, if the treating physician provides sufficient information in the chart to show the need for a service, the RAC should defer to that decision.

3. RAC DETERMINATION OF MEDICAL NECESSITY

In determining whether coverage for a particular service or item exists, the RAC will look to the Medicare statute, regulations and other guidance, including Medicare's policy manuals and transmittals. Where the Medicare statute is silent on a particular service or item, CMS may issue a National Coverage Determination ("NCD") that provides whether Medicare will cover a particular item or service, and the population for whom it may be covered. If no NCD has been issued, or an NCD requires further clarification, Medicare contractors, carriers and intermediaries may develop Local Coverage Determinations ("LCDs").

The following is a non-exhaustive list of resources that a RAC will use for guidance on whether an item or service is reasonable and necessary and therefore reimbursable.

A. Medicare Benefit Policy Manual

The Medicare Benefit Policy Manual provides general coverage instructions that are not National Coverage Determinations. The Manual contains instructions on the coverage of various services including, but not limited to, inpatient hospital services, psychiatric hospital services, hospital services covered under Part B and skilled nursing services. The manual is located at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

B. National Coverage Determinations

A NCD is a national policy statement granting, limiting, or excluding Medicare coverage for a specific medical item or service.[10] According to the Medicare Program Integrity Manual:

> NCDs are developed by CMS to describe the circumstances for Medicare coverage for a specific medical service, procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under § 1862(a)(1) [the reasonable and necessary section] of the Act or other application provisions of the Act.[11]

It is CMS and not local contractors who develop and publish NCDs, which are binding on beneficiaries, providers, contractors (including RACs), and reviewers up to and including an Administrative Law Judge.[12]

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[10] 42 U.S.C. §1395ff(f)(1)(B).
[11] Medicare Program Integrity Manual, Chapter 13, §1.1.
[12] 42 U.S.C. §1395ff(f).

NCDs can be found at http://www.cms.hhs.gov/coverage/ or in the National Coverage Determination Manual.[13] Additionally, the Medicare Coverage Database at CMS's web page contains all NCDs and LCDs, local policy articles, and proposed NCD decisions. The database also includes several other types of national coverage policy related documents, including national coverage analyses ("NCA"), coding analyses for labs ("CAL"), Medicare Evidence Development & Coverage Advisory Committee ("MedCAC") proceedings, and Medicare coverage guidance documents. It may be important for hospitals to review information posted on this web page periodically. Importantly, if a service is not documented in accordance with an NCD, it is not reimbursable.

EXAMPLE:

The following is an example of an NCD. Although other NCDs may be more extensive, it is included here to assist in understanding the principles applied.

NCD For Ambulatory EEG Monitoring (160.22)

Coverage Topic

Diagnostic Tests, X-rays, and Lab Services

Item/Service Description

Ambulatory, or 24-hour electroencephalographic (EEG) monitoring is accomplished by a cassette recorder that continuously records brain wave patterns during 24 hours of a patient's routine daily activities and sleep. The monitoring equipment consists of an electrode set, preamplifiers, and a cassette recorder. The electrodes attach to the scalp, and their leads are connected to a recorder, usually worn on a belt.

Indications and Limitations of Coverage

Ambulatory EEG monitoring is a diagnostic procedure for patients in whom a seizure diathesis is suspected but not defined by history, physical or resting EEG. Ambulatory EEG can be utilized in the differential diagnosis of syncope and transient ischemic attacks if not elucidated by conventional studies. Ambulatory EEG should always be preceded by a resting EEG.

Ambulatory EEG monitoring is considered an established technique and covered under Medicare for the above purposes.

[13] CMS Pub. 100-3; http://www.cms.hhs.gov/Manuals/IOM/list.asp.

Thus, if the Beneficiary's record identifies syncope, ambulatory EEG should be covered under this NCD.

C. Local Coverage Determinations

A majority of Medicare's policies are established at the local level when Medicare contractors indicate whether a service is considered reasonable, medically necessary, and appropriate. These policies, formerly termed Local Medical Review Policies ("LMRP"), are now referred to as Local Coverage Determinations, as a result of the Benefits Improvement and Protection Act of 2000.

LCDs are contractor-specific policies that identify the circumstances under which specific services, items or drugs will be covered as well as the codes that describe medical necessity.[14] LCDs are developed by contractors in response to provider requests based on evidence of need, the development of new technology or other services for which no established standard of practice exists.[15] Importantly, LCDs must be consistent with NCDs. Georgia Medicare Part A LCDs can currently be found through the NCD website or at http://www.georgiamedicare.com/MedicalReview.cfm.

In sum, NCDs address coverage of items and services under the Medicare statute. LCDs specify the particular clinical circumstances under which an item or service will be covered and/or the circumstances when the covered service will be deemed reasonable and necessary.

PRACTICE TIPS:

- *Although the RACs may use LCDs in reviewing claims, LCDs do not have the same legal effect as NCDs.*[16] *Therefore, in the event the RAC applies the LCD as a "hard and fast" rule to deny a claim, a hospital could have grounds to appeal that determination*

- *With the consolidation of review activities under MACs, many LCDs are being re-examined and harmonized across regions. Therefore, it is critical for hospitals to monitor the status of LCDs that RACs could use in reviewing their claims. The LCDs are posted with any suggested changes so that providers can submit information in support of its position. It may be that working in conjunction with the Medical Association of Georgia and specialty medical societies, hospitals can ensure that LCDs are consistent with accepted clinical standards.*

[14] 42 U.S.C. §1395ff(f)(2)(B).
[15] *Id.*
[16] 42 U.S.C. § 1395ff(f).

D. Hospital Guidance and Other References That Can Be Persuasive in Supporting Medical Necessity

Several medical necessity screening tools are available that Medicare or its contractors in specific jurisdictions may choose from to determine if hospital admissions are medically necessary. Although Georgia Medicare Part A, states that it bases its determinations on the criteria contained in the Medicare Benefits Policy Manual (CMS PUB 100-2, Chapter 1 – Inpatient Hospital Services), a RAC reviewer could use this standard or apply other measures in reviewing claims.[17]

Specifically, RAC reviewers have used the InterQual and Milliman standards to assess the medical necessity of services. Although these standards may be widely accepted, they are guidelines, not per se requirements, that may be satisfied to demonstrate that services should be reimbursable.

E. Resources Hospitals Could Consider Referencing to Support Medical Necessity

There are a host of resources that could be referenced to support the medical necessity of services. Listed below are some of the more commonly-used references that may be used to support reimbursement for services.

(1) Coding Guidelines

Certainly, hospitals can support medical necessity of services by referencing coding guidelines and clarifying manuals.

(2) Medical Journals, Publications and Other Reference Articles

If you are asked to substantiate the necessity for care, journal articles or references may be important to identify for RAC reviewers. Because hospitals and clinicians may be more able to readily access these articles than contractors, it may be useful to include copies of particularly relevant documents with medical records that are forwarded for review.

(3) National Guidelines Clearinghouse

National Guideline Clearinghouse ("NGC") is a public resource for evidence-based clinical practice guidelines. NGC is a program of the Agency for Healthcare Research and Quality, United States Department of Health and Human Services that offers a synthesis of selected guidelines that cover clinical topic areas and expert commentary on issues of interest and importance to the clinical community. NGCs can be found at http://www.guideline.gov.

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[17] *See* http://www.georgiamedicare.com.

***PRACTICE TIP**: The NGC includes peer-reviewed guidelines that could be particularly useful in supporting the medical necessity of services.*

4. THE MEDICAL RECORD: PRACTICAL CONSIDERATIONS IN PRODUCING DOCUMENTS TO THE RAC

A. Medical Record Review by the RACs

When a RAC requests medical records, a provider has 45 days in which to provide those records unless the RAC grants an extension. Because this is not a lot of time, particularly when an organization may be addressing other demands for medical records, hospitals should consider developing a centralized process for tracking, gathering, copying, and sending these requests. Some things to consider when developing such a process include:

- Designating a particular individual to receive and track RAC medical record requests;
- Determining whether you should seek an extension of time within which to respond and who will be responsible for requesting and tracking such extension;
- Considering how and who will quickly obtain any requested medical records;
- Considering having a physician/clinical advisor review the records to determine that all relevant and necessary information is included;
- Developing a system for copying and assembling these requests;
- If you elect to produce copies of the requested records, be sure you invoice them for the costs of copying the documents; and
- Tracking the records when you mail them to ensure that the records were received and when.
- Developing a database or system for tracking all RAC requests. It can be helpful to implement a tracking system that houses all important information related to the RAC process. The tracking mechanism should be updated regularly and include the individual responsible for each task. Further, because CMS will limit the total number or claims that a RAC can request from a provider during a specific time frame, consider designating an individual to be responsible for tracking the total number of claims requested by the RAC.

B. Submitting Medical Records to the RAC

Auditors usually will not dig through a chart to justify a charge; thus it is critical that the record be presented in a legible, understandable and comprehensive manner. Below are some common pitfalls to consider when making copies of records to send to the RAC:

- Make sure that you have the complete record! Ensure that records supporting the services that are housed in other areas of the hospital (*e.g.* pharmacy, laboratory or another provider's office) are included. Determine whether some of the records maybe available electronically as well as on paper.

- Make sure that if you make copies they are one sided. Also make sure that if the original record is two-sided you get both sides.

- Make sure copies are legible. If the records are illegible – due to handwriting or because of copy quality – auditors will often deny the service. Have records with poor handwriting transcribed, which must be identical to the written note – even typos.

- Make sure records are copied completely. (*e.g.* make sure part of the record does not get cut off). Note that if paper copies are made of entries made in electronic medical records (EMRs), it can be difficult to read. This is particularly true when an EMR has a "background" color or something similar that results in the copied pages having a gray background.

- If acceptable to the RAC, a hospital may consider scanning records to produce them in an electronic format. If you opt for this method, it is important that the scanned records are clear and legible. Also, if there are multiple files that are created in scanning, it may be important to title the file for ease of review. For instance, if a patient has a voluminous record, it may be that a particular pdf file only contains physician orders or lab results for a certain time period. It could be helpful to name the pdf file "Lab Results 1/1/08-4/1/08" for ease of review.

- Organize records in a logical and easy to find manner. Consider binding and tabbing records if time permits.

- Consider Bates labeling the records (numbering pages with a sequential code). Make sure to keep an identical copy of the records sent to the RAC for reference purposes and to prevent the RAC from later arguing that a particular record was not submitted.

C. Comprehensiveness and Quality of Medical Record Documentation

When a RAC requests records for medical necessity reviews, hospitals will not have particularly long times to gather the charts. Despite these time constraints, it may be that your RAC Team/Coordinator will have an opportunity to review at least some of the records to assess their effectiveness in documenting medical necessity before they are sent to the RAC.

If after reviewing the record, the RAC Team determines that records have some deficiencies or are otherwise incomplete there may be some measures that can be used to address perceived deficiencies prior to sending records to the RAC. **ORIGINAL ENTRIES IN MEDICAL RECORDS, HOWEVER, SHOULD NEVER BE MODIFIED OR ALTERED.** Listed below are some suggestions for documenting medical necessity of services:

- **Narratives summarizing patient's course of treatment:** If a patient has a complicated history, a summary of the overall course, highlighting critical points in care may be useful. In addition, if notes are cryptic or contain shorthand references or abbreviations, summaries explaining or otherwise translating the record may be helpful to include. Although ideally, the treating physician would prepare or sign and date this later-prepared statement, the additional documentation could be prepared by another clinician or hospital staff. Any such narrative should be clearly designated as such.

- **Letters from Treating Providers:** If a treating provider prepares a letter in support of the medical necessity of care, that can be included with the records sent to the RAC.

- **Missing Signatures or Dates on Orders**: Please refer to Chapter 6, Appeals. RACs have been directed not to deny claims for minor omissions, such as a lack of signatures, dates, etc. If, in preparing records for the RAC, such deficiencies are identified, they could be addressed in accordance with the hospital's policy for later included information or addendums.

- **Records from Other Providers:** It may be that another provider (such as a physician) has separate records that could be useful in substantiating the need for the services. Under the HIPAA Privacy Rule, the other provider can give you copies of those records to include with the hospital's in support of your payment purposes.

APPENDIX A

COMMON MEDICAL NECESSITY DENIALS MADE DURING THE RAC DEMONSTRATION

RAC Denial	Reason for Denial	Example	Standard
Excessive units	Hospital unnecessarily submits claims for multiple services/items	Hospital submits claim for 3 colonoscopies for same beneficiary on same day; Physician submits claim for 6 vials of Neulasta when patient actually received 6 milligrams of Neulasta	Hospitals must be careful about the importance of listing the accurate number of "units of service" on a claim. Compliance audits should verify correct billing of services.
Very short stay/One-day stay - inpatient cases	Physician documentation does not support medical necessity of admission; physician does not have understanding of admission/observation criteria	A beneficiary presents to the emergency room with shortness of breath. EKG is normal. Chest x-ray rules out pneumonia. The hospital admits the beneficiary for a one-day hospital stay. Medical record reviews indicates no reason why the services could not have been performed on an outpatient basis	Make sure there is a valid order to admit for inpatient status. Record should include documentation for the medical *need and reason* for admission.
Inpatient rehabilitation	Services could have been performed in a less acute setting	An Inpatient Rehabilitation Facility (IRF) submitted a claim for inpatient therapy following a single knee replacement. The	IRFs must be careful when admitting Medicare beneficiaries for inpatient therapy to make sure that the Medicare medical necessity criteria are

		Medical records indicate that although the beneficiary required therapy, the beneficiary's condition did not meet Medicare's medical necessity criteria for IRF care.	met. Hospitals should be aware of the medical necessity criteria in HCFA Ruling 85-2 and the Medicare Benefit Policy Manual section 110.
Debridement	Coding requirements for debridement state that unless the attending physician documents in the medical record that an *excisional* debridement was performed (definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of the skin should be coded to non-excisional debridement of skin	In the medical record, the physician writes "debridement was performed" and fails to indicate excisional debridement	When excisional debridements are performed, hospitals must ensure that the coding clinic guidelines are followed and "excisional debridement" is noted. Additionally, records should indicate the type(s) of tissue removed (e.g., skin and subcutaneous tissue).
Wrong diagnosis	Coding guidelines not met	Hospital reported a principal diagnosis of septicemia, but medical records show diagnosis of urosepsis, not septicemia or sepsis	Hospitals must list an accurate principal diagnosis for beneficiaries (particularly those with a urinary tract infection). Laboratory findings should be included in physician notes supporting the correct diagnosis/infectious agent(s).

CHAPTER 5:

EVALUATION OF ARKANSAS LAW AND MEDICARE PAYMENT POLICY ISSUES ARISING UNDER THE CASE MANAGEMENT ASSIGNMENT PROTOCOL

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I. Introduction

This memorandum is in response to the request of the Arkansas Hospital Association for an evaluation of the Case Management Assignment Protocol ("CMAP") to identify legal issues that may present obstacles for the implementation of the Protocol by Arkansas hospitals.

II. CMAP Background

In 2003 Florida Medical Quality Assurance, Inc. ("FMQAI") conducted a pilot project for the purpose of developing methods to decrease unnecessary admissions in Florida Hospitals.[1] FMQAI 's supposition was that unnecessary admissions were due to lack of documentation by physicians to support the medical necessity of admissions and also physician lack of knowledge and understanding of hospital admission criteria.

To address these concerns FMQAI developed the Case Management Protocol. The Protocol was designed to increase the number of hospitalized patients who were assigned to the correct inpatient vs. observation (outpatient) status; to decrease unnecessary admissions; and to decrease the payment error rate. The CMAP protocol focuses particularly on short stay ($\leq$ two days) admissions for symptom codes rather than diagnosis codes and admissions through the emergency department. A critical feature of the Protocol was the evaluation, and determination, of patients' status by case managers before the attending physician entered an order admitting the individual as an inpatient. These case managers were intensively trained in the hospitals' admission criteria.

FMQAI recruited 20 acute care hospitals with high utilization of short stay admissions and symptom DRG's to implement the Case Management Protocol. Analysis of baseline data revealed 39.2% inpatient admission denials. After implementation of the CMAP pilot program at the hospitals, retesting indicated that admission denials were reduced by 67%. Similar success was achieved in a later six state pilot project funded by CMS.

III. CMS Response to CMAP Pilot Projects

Because of the highly favorable results in decreasing unnecessary admissions that were obtained through use of the CMAP procedures in CMS sponsored pilot projects, the QIOSC for the Hospital Payment Monitoring Program Task inquired of CMS whether it would adopt or approve the CMP protocol as an effective tool for addressing hospital admissions issues.[2]

CMS responded to the inquiry stating that it does not recommend or approve any particular case management protocol. Further, CMS cautioned that each hospital is responsible

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[1] FMQAI is under contract with CMS as the Quality Improvement Organization ("QIO") for Florida.

[2] For certain topics, settings, populations, and project processes, CMS has contracted with a single QIO to provide support for CMS and all QIOs in that particular area. These specially tasked QIOs are termed Quality Improvement Organization Support Centers ("QIOSC"). See CMS Quality Improvement Organization Manual, Chapter 16, §16050 (B).

for ensuring that whichever case management protocol it adopts remains consistent with evolving Medicare policies. Also, CMS noted that state law may impact the use of admission protocols, and each hospital must ensure compliance with such state laws.

IV. Summary of Conclusions

No case management protocol will substitute for, or supersede, Medicare's payment policies, so the effectiveness of the protocol to properly assess the level of care for admissions depends on it being consistent with Medicare standards.[3] Given the continuing development and modification of these medical standards, a case management protocol is always a work-in-progress. An essential feature of an acceptable protocol must therefore be a procedure for continual review and updating.

The purpose of this memorandum, however, is to identify legal obstacles to the implementation of a CMAP type of process for Arkansas Hospitals. Our review has revealed no fundamental obstacle to adoption of such a system. Nevertheless, features of the CMAP procedure do raise issues under Arkansas law and Medicare payment policy. Hospitals should be aware of these concerns, so that their policies and protocols can address the issues in a manner to clearly demonstrate compliance. The two main areas of concern are the clear identification of the professionals who are the decision makers at each step in the process, and the level-of-care status of the patient at all times as the individual moves through the process.

V. CMAP Process

FMQAI recommends that the process be implemented through a standing order for all patients, regardless of payer source, rather than as a "prn" option at the discretion of individual physicians. When a physician decides that a patient needs to be treated in a hospital setting, the Protocol is initiated through an order to the effect, "Assign status per Case Management Protocol," or "Admit patient per Case Management/Utilization Management Protocol."

Case management/utilization management personnel ("case managers") then evaluate the patient under the hospital's admission criteria and assign the patient to the appropriate status (i.e. inpatient vs. observation). The decision is described as binding and is supported by a signed order of the attending physician. If the physician disagrees with the determination, he/she can discuss the case with the physician advisor or the UR committee. (See, 42 CFR §482.30(d) for procedures for resolving disagreements between the UR Committee and the attending physicians). The CMAP protocol apples only to initial determinations of status and is not applied to changes that may occur later.

[3] The Medicare standards are expressed in such materials as Medicare's National Coverage Determinations ("NCDs") and Local Coverage Determinations ("LCDs"), Medicare's Inpatient Only List of procedures as well as such proprietary systems for assessing medical necessity such as the screening criteria of InterQual and Milliman & Robertson Care Guidelines.

The Protocol specifies the maximum amount of time allotted to the case managers to make a status determination for a patient, e.g. 2 – 6 hours. "Observation" status is the default status if case managers do not make a decision within the specified timeframe.

VI. Regulatory Framework

In order to receive Medicare reimbursement for services provided to a program beneficiary not only must the services be covered by Medicare as a program benefit, the services must also be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" of the specific patient who is to be furnished the service. 42 U.S.C. §1395y(a)(1)(A). According to Medicare's Program Integrity Manual, an item or service is "reasonable and necessary" if it is,

- Safe and effective
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
- Appropriate, including the duration and frequency that is considered appropriate for the services, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's medical needs and condition;[4]
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative.

To ensure that its services meet these standards, hospitals are required by the Medicare Conditions of Participation to have a utilization review ("UR") plan in effect.[5] The hospital can implement the plan either through a staff committee of its own or by contracting with an outside source that meets the standards of 42 CFR §482.30 (b)(1). The committee must include at least two doctors of medicine or osteopathy. 42 CFR §482.30 (b). Other members can be the practitioners identified in 42 CFR §482.12(c)(1). The hospital's UR plan must provide for the review of Medicare and Medicaid patients with respect to the medical necessity of

i. Admissions to the institution,
ii. The duration of stays , and
iii. Professional services furnished, including drugs and biologicals.

[4] There are several commercial products available that provide criteria for level of care and medical necessity determinations , including InterQual criteria and Milliman & Robertson Care Guidelines.

[5] There are two regulatory exceptions to this requirement: if a QIO has assumed binding review for the hospital and if the hospital is in a state which has established Medicaid utilization review standards that CMS has determined to be superior to the Medicare standards and with which the hospital must comply. 42 CFR §482.30 (a)(1)(& (2).

The reviews may be performed before, at, or after hospital admission and, with a few exceptions, they may be performed on a sample basis. 42 CFR §482.30(c).

VII. Resolution of Disagreement Between Attending Physician and Case Manager

The UR committee determination that an admission or continued stay is not medically necessary can be made by one member of the UR committee if the physician responsible for the patient's care concurs with the UR decision, or fails to present his/her views when offered the opportunity. In all other situations the decision that the admission or continued stay is not medically necessary must be made by two members of the committee. 42 CFR §482.30 (d) (1) & (2).

Before the committee decides an admission or continued stay is not medically necessary, it must afford the practitioner or practitioners responsible for care of the patient an opportunity to present their views. If the committee decides that the admission or continued stay is not medically necessary written notification not later than 2 days after the determination must be given to the hospital, the patient, and the practitioner or practitioners responsible for the patient's care. 42 CFR §483.30 (d) (2) & (3).

VIII. Patient Admission Status later determined By UR Review to be incorrect.

A. Incorrect Inpatient Admissions:

When a patient is admitted as an inpatient but it is determined later that the patient did not meet inpatient admission level of care criteria, the hospital has a limited opportunity to recast the admission as outpatient under Condition Code 44 procedures. Otherwise the hospital is relegated to billing under part B for certain services and items that the patient received during his/her hospital stay.

Under Condition Code 44 procedures the hospital may change the beneficiary's status retroactively from inpatient to outpatient and submit an outpatient claim for medically necessary Medicare part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to the patient's discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The physician responsible for the patient's care concurs with the UR committee's decision; and
4. The physician's concurrence with the UR committee's decision is documented in the patient's medical record.

If all of these conditions apply, then the hospital may treat the entire episode of care as though the impatient admission never occurred, and may submit a claim for an outpatient

episode of care. Medicare Claims Processing Manual, Chapter 1, Section 50.3. See also, CMS Med Learn Matter, SE0622 (September 10, 2004).

If all of the conditions for Code Status 44 are not met, then the hospital cannot seek payment for either an inpatient or outpatient episode of care. But, it may be able to seek payment under Part B for certain items and services furnished to the patient during his/her stay. This option is available to PPS hospitals if:

- No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission;
- The admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made);
- The day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability);
- The patient was not otherwise eligible for or entitled to coverage under Part A (See Medicare Benefit Policy Manual, Chapter 1, §150, for services received as a result of noncovered services); or
- No Part A day outlier payment is made (for discharges before October 1997) for one or more outlier days due to patient exhaustion of benefit days after admission but before the case's arrival at outlier status, or because 6outlier days are otherwise not covered and waiver of liability payment is not made.

For non-PPS hospitals, Part B payment may be made for services on any day for which Part A payment is denied (i.e., benefit days are exhausted; services are not at the hospital level of care; or patient is not otherwise eligible or entitled to payment under Part A). See, Medicare Benefit Policy Manual, Chapter 6, §10.

B. Observation Admission Later Determined to have Qualified Under Inpatient Criteria

In those situations where an Observation admission is later evaluated as actually qualifying under inpatient admission criteria, there is no procedure, comparable to Condition Code 44, to retroactively recast the admission as inpatient. The patient is afforded inpatient status only prospectively from the time an order is entered admitting the individual as an inpatient. Until the time of the inpatient order, the individual's status remains Observation.

There are several Medicare principles, however, which may alleviate the reimbursement effects of this issue if prompt action is taken before the patient is discharged or released from the hospital and the patient's status can be changed prospectively to inpatient. The day of inpatient admission is considered by Medicare as the first day of inpatient status. Medicare Claims Processing Manual, Chapter 3, §40.1.A. Thus, if the determinations of observation and then inpatient status occur on the same day, the later inpatient determination will control at least treatment of the remainder of the day as an inpatient day.

Also, Medicare has what is termed a "three-day payment window" for outpatient diagnostic and therapeutic services provided before an inpatient admission. Such services are

deemed to be inpatient services and included in the inpatient payment (unless there is no Part A coverage). Medicare Claims Processing Manual, Chapter 3, §40.3.B & .C. The Services must be provided by the admitting hospital or by an entity wholly owned by the admitting hospital. Also, the therapeutic services must be related to the admission, i.e. there must be an exact match between the ICD-9-CM principle diagnosis code assigned for both the preadmission services and the inpatient stay. If, however, the re-evaluation of the observation stay, (finding that it would have qualified under inpatient criteria), occurs more than three days after the observation services were furnished, there is no procedural vehicle in Medicare to recast the Services as inpatient, Part A, reimbursable.

IX. Implementation Legal Issues

The CMAP process, by employing highly trained medical reviewers at the outset of every patient/hospital admission encounter in lieu of retrospective review on a sample basis, would necessarily result in a high degree of accuracy in status determinations. Hospital revenues would thus be safeguarded from large losses due to medical necessity errors. There are, however, certain legal issues that, while not prohibitive of the CMAP protocol, nevertheless must be carefully addressed to assure compliance with state and federal laws regarding patient care management.

A. Authority to Admit (Scope of Practice)

The CMAP protocol places significant responsibility on case Management/ utilization review staff to evaluate a patient's level of care, even to the extent of describing their decisions as "binding". This language can raise concerns about the scope of practice of the professional reviewers who are making decisions under the Protocol. The authority under state law of the reviewers to admit patients to the hospital seems to be implicated by the use of such language.

Taken as a whole, however, the use of language such as "binding" to describe the reviewer's decisions appears to be misleading. The CMAP process actually is physician driven, with the attending physician writing the order for admission to the case management protocol and then, after the CMAP review, signing the order implementing the reviewers' level of care determinations. Disagreements between the attending physician and reviewers are resolved through the procedures established by Federal regulations for disputes in the UR process. See, 42 CFR §482.30 (d); and Section VII, above. The CMAP process fits neatly into the UR procedures, established by federal regulation. CMAP is a more intense version of the procedures commonly implemented by hospitals under the federal regulation, but not of a different kind.

The use of strong language to describe the definitiveness of the reviewer's determinations, does however, introduce ambiguity in identifying the person who is actually ordering the admission of the patient or changing the level of that patient's care. This ambiguity may raise issues regarding the scope of the case manager's authority under the protocol and under state law which would be best to avoid. Some or all of the first level case managers who perform the CMAP reviews may not be authorized under state law to admit patients or change level of care from inpatient to outpatient, or vice versa.

Under Medicare Conditions of Participation an individual can be admitted to a hospital only by a practitioner authorized under state law to admit patients to hospitals. 42 CFR §482.12 (c)(2). Furthermore, Medicare takes the position that case managers or other utilization management staff, who are not licensed practitioner's permitted by state law to admit patients to a hospital or are not doctors of Medicine or osteopathy would not have the authority to change a patient's status from inpatient to outpatient. Med Learn Matter Number SE0622 (September 10, 2004) (Answer to Question #4).

The Practitioners identified in the Medicare Conditions of Participation as authorized to admit are doctors of medicine and osteopathy, and, within the scope of their license: doctors of dental surgery, doctor of podiatric medicine; doctor of optometry; chiropractor; and clinical psychologist. The Medicare conditions also permit patients to be admitted by practitioners other than those listed above, but those patients must be under the care of a doctor of medicine or osteopathy. 42 CFR §482.12 (c) (2). However, only Physicians, both M.D. and D.O., are authorized to admit patients to hospitals under Arkansas law. See, Rules and Regulations For Hospitals and Related Institutions in Arkansas, § 5(A)(10).

Because of the significance of the person who orders the admission or changes the level of patients' care, the hospital should clearly delineate in the Protocol the status and credentials of those who are authorized to make those determinations. There are at least two approaches to the case manager's initial decision as to level of care. In the first option the case manager's determination is explicitly identified as a recommendation which to be effective must be endorsed by the attending physician, through a countersignature, or which must be endorsed or reversed through the disagreement resolution provision. The resolution of the disagreement also must be documented through the countersignature of either the attending physician or an individual authorized to admit patients to the institution. The benefit of this first approach is that case management staff reviewers need not be composed of practitioners who are authorized to admit. It is only necessary that those who resolve disagreements between case managers and attending physicians have the authority to admit.

The second approach would involve treating the "assign to case management" order as a delegation of the task to the case management staff with a member of that staff entering the order as to level of care. This would require, however, that all case managers, or at least their supervisors who would have to sign the orders, have the authority to admit. There would still need to be notification to the attending physician and an opportunity for the attending to initiate the disagreement resolution process before the case management staff could enter the level of care order. This would appear to be a more cumbersome and expensive process because of the additional requirements imposed on case management staff qualifications.

B. Status of Patient Prior to Level of Care Determination

From the time the attending physician enters an "admit to case management" order until the level of care is formally determined, hours may elapse during which the patient is furnished medical items and services. The status of the patient during this time is therefore significant for billing purposes. Unfortunately the CMAP protocol does not explicitly address this important issue, which should be clearly denoted in the Protocol.

A CMAP decision to admit a patient as an inpatient resolves many of the issues regarding this early period of the patient's presence in the hospital and any services the individual may have received. As discussed above, (Section VIII.B), a patient is treated as an inpatient for the entire day the individual is admitted as an inpatient. Furthermore, there is a three (3) day look-back provision for diagnostic and therapeutic services furnished before an inpatient admission. There is currently no vehicle for retrospectively transforming an outpatient/observation stay into an inpatient admission, but the 3-day window discussed above and the entire-day-of-inpatient admission rules should greatly alleviate the reimbursement consequences of a delayed inpatient status determination.

The problem therefore centers on the services a patient may receive during the period that may elapse before case management determines that the proper level of care is observation. There is no sort of 3-day window that allows the observation status to relate back. When a physician orders a patient to be placed under observation, the patient's status is that of an outpatient. Medicare Benefit Policy Manual, Chapter 6, §20.6(B). A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or critical access hospital ("CAH"). Hospital Benefit Policy Manual, Chapter 6, §20.2. Observation services are covered by Medicare only when provided by the order of a physician or another individual authorized by state law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Hospital Benefit Policy Manual, Chapter 6, §20.6 (A). Medicare provides:

> Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field of the reported observation HCPCS code.

Medicare Claims Processing Manual , Chapter 4, §290.2.2

Furthermore, observation services are billed by the hour. Medicare Claims processing Manual, Chapter 4, §290.5.1.

In view of the inability to "relate back" observation status for reimbursement, it appears that it would be in the hospital's interest to clearly define the patient's status during the period before the CMAP decision is made. The vagueness on this point of an order that simply says "admit to case management protocol" could be resolved by the admitting practitioner signing an order which states "admit to observation pending case management evaluation of level of care." Such an admission, pending evaluation of the patient under the hospital's inpatient admission criteria, is consistent with Medicare's stated intent for the status of observation: "the purpose of observation is to determine the need for further treatment or for inpatient admission." Medicare Benefit Policy Manual, Chapter6, §20.6(B).

Admitting the patient for observation pending the completion of the CMAP process appears to be a proper utilization of observation status under CMS policy, as noted above. Furthermore, if the decision under the CMAP protocol is to admit the individual as an inpatient, then the inpatient day of admission rule as well as three-day payment window, discussed above, should enable the hospital in some cases to bill the observation services that were initially provided as inpatient services with little or no loss of revenue.

X. Conclusion

The CMAP process is a valuable tool in to ensure that individuals are admitted to a hospital at the most appropriate level of care. There are no impediments under Arkansas law to a hospital adopting such a system. There are, however, certain specific requirements of Arkansas law and Medicare payment policy that must be met for a hospital to benefit from a case management system. Hospitals should design their Protocol so that it will provide clear documentation of compliance with those requirements. Hospitals should pay particular attention to the identification of the professionals who make the Protocol's critical decisions, as well as to the clear identification of the status of the patient, either as outpatient or inpatient, at all times as they move through the CMAP process.

CHAPTER 6:

APPEALS

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Table of Contents

The material contained in this chapter was compiled in November 2008. The chapter presents information on legal matters of general interest in legal form. This document should not be construed as legal advice or opinion on specific matters.

A. Introduction

The preceding chapters of this Manual have explained the goals of the RAC, program, the types of issues that are considered by the RACs when they are reviewing claims, how RACs perform the reviews and their stake in determining allegedly incorrect payments. This chapter will address RAC actions that target individual providers and will offer guidance in responding to these RAC activities. In particular we will discuss RAC letters which request documents and RAC determinations of incorrect payments.

Hospitals that receive RAC determinations of allegedly incorrect payments, that the hospitals believe are unjustified, should give serious consideration to appealing the determinations through the administrative appeals process discussed below. The success rates of these appeals have been very favorable, most especially in regard to claims denied by Connolly Consulting Associates, Inc. Connolly is the RAC chosen for Region "C" which includes Georgia.[1] According to a Report issued by CMS in September 2008, updating its Evaluation of the 3-Year RAC Demonstration Program, of the Connolly denials appealed through June 30, 2008, 54.6% of the appeals involving Part A claims and 64.7% of the appeals involving Part B claims were decided favorably to the provider. The combined Part A and Part B rate was 57.4%. Furthermore, since CMS included appeals filed but not yet decided in calculating the percentage of provider-favorable decisions, the actual percentage of provider-favorable decisions to decisions-issued is even higher.

B. Types of RAC Reviews

As discussed in previous sections of the Manual, RACs perform two types of claims reviews that can result in determinations of incorrect payments: Automated Reviews and Complex Medical Reviews.

1. Automated Reviews

When the review is automated, the RAC uses available electronic information and determines incorrect payments based solely on computer analysis without the intervention of RAC personnel. This type of review is permissible only in situations where there is certainty that the services are not covered or were incorrectly coded, or that there was a duplicate payment or other claims related overpayment. The requirements of PIM §3.5.1 must be met.[2] The automated review must:

- Have a clear policy that serves as a basis for denial; or

[1] Two unsuccessful bidders for the RAC program have filed protests with the GAO of the award of RAC contracts for the permanent program. As a result of these protests an automatic stay has been issued on the contract work of all four RACS who were awarded the contracts for the permanent program. Under the terms of the Competition and Contracting Act of 1984 ("CICA"), GAO must issue a decision in 100 days, which would be in early February, 2009.

[2] The Medicare Program Integrity Manual. See, www.cms.hhs.gov/Manuals/IOM

- Be based on a medically unbelievable service(s); or

- Occur when no timely response is received to an ADR (additional records request) letter.

"Clear policy" means a statute, regulation, National Coverage Determination ("NCD"), coverage provision in an interpretive manual, or Local Coverage Determination ("LCD") that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that can be used as the basis for frequency denials must contain utilization guidelines that the RAC considers acceptable for coverage.

Automated Reviews do not involve requests for medical records or other documents from the provider because the determination of incorrect payment is based solely on computer analysis of information already in the government database. The one exception to this rule is that overpayment determinations based on a providers' failure to timely respond to a RAC request for documents are classified as an automatic review determination.

2. Complex Medical Reviews

Complex reviews are conducted when the requirements for an automated review are not met. Complex Medical review is used in situations where there is a high probability (but not a certainty) that the service is not covered and copies of medical records will be needed to provide support for the overpayment. These reviews require the application of clinical judgment by a licensed medical professional in order to evaluate medical records.

C. Medical Record Requests

These requests certain identified medical records are sent to providers when there will be a complex medical review. A copy of a typical records request from the Demonstration phase of the RAC program is attached as Exhibit "A".

1. Timeframe to Respond

The request for records will advise the provider that it has 30 days to submit the documents, but the RAC does not consider the provider delinquent until 45 days have elapsed. A provider who is having difficulty meeting the deadline can request an extension from the RAC. If the RAC has not received the requested records by the deadline, and if no extension has been granted, the RAC is authorized to find the claim to be an overpayment.

During the Demonstration phase of the RAC project, many hospitals were subjected in a short time period to multiple RAC record requests, involving thousands of pages of records. It was exceedingly difficult for these hospitals to provide the records within 45 days and RACs were not as cooperative as they could have been in granting

extension of time. CMS has indicated it will take action to alleviate this situation (see below, "Limit on Records Requests"). Nevertheless, it would be best for Hospitals to have in place a plan to copy voluminous records and track both timelines for response and deadlines for RAC Determinations. Many Hospitals arranged for outside contractors to copy the records, and purchased tracking systems from outside vendors.

2. Limit On Records Requests

CMS has instructed the RACs to use discretion to ensure the number of medical records requested do not negatively impact the provider's ability to provide care. To strengthen this protection CMS has issued specific limitations on the number of records that may be requested within a specific period of time. The medical record limits for FY 2009 are:

- Inpatient Hospital, IRF , SNF , Hospice (per NPI)
  - 10% of average monthly Medicare claims (with a maximum of 200) per 45 days.

- Other Part A Billers (Outpatient Hospital, HH) (per NPI)
  - 1% of average monthly Medicare services (with a maximum of 200) per 45 days.

- Physicians (per NPI)
  - Solo Practitioners: 10 medical records per 45 days
  - Partnerships 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 Billers (DME, Lab) (per NPI)
  - 1% of average monthly Medicare services per 45 days.

3. RAC On-Site Visit

Alternatively, the RAC may attempt an on-site visit to the provider to review medical records, but the provider may refuse to allow access to its facility. The RAC is prohibited by CMS from making an overpayment determination based upon the refusal of access. Instead the RAC must make a written request for the needed records.

4. RAC Payment For Medical Records

RACs must pay for photocopying medical records associated with an acute care inpatient prospective payment system (PPS) hospital DRG claim and a Long Term Care Hospital claim. The formula calculation for the rate can be found at 42 CFR §476.78(c). RACs are permitted, but are not required, to pay for medical records associated with other types of claims.

According to a CMS statement in the FAQ section of its RAC Web Page, reimbursement in July of 2008 was 12 cents a page. Providers will not be required to submit vouchers. The RACs are supposed to automatically issue payments to the hospitals for photocopying charges. RACs will be required to pay for copying on a monthly basis, and all checks should be written within 45 days of receiving the medical record. Hospitals would be well advised, however, to track copying expenses and reimbursements to ensure appropriate payment is received.

5. Electronic or Imaged Medical Records

CMS encourages, but does not require, RACs to accept imaged or electronic medical records. RACs must pay the same per page fee for the production of imaged or electronic records as they pay for hard copies. Before submitting records in this form, providers must successfully complete a connectivity and readability test with the RAC system.

6. Keep Track Of Records Submitted To The RAC

Providers should establish a system for keeping track of RAC records requests. The system should include the dates of the requests, the dates of any requests for extensions and any extensions granted, as well as copies of all records submitted to the RAC and the dates they are submitted. An alert feature should be a part of the system so that that staff responsible for responding to and tracking RAC requests will be notified of upcoming deadlines.

CMS requires that RACs make information about the status of medical records (i.e. outstanding, received, review underway, review complete, case closed) available to providers upon request. Therefore, if you have questions and/or problems and want to verify the status of the review, you can contact the RAC for that information.

It is important to remember also that by January 1, 2010, CMS is requiring RACs to develop a Web-based application that will be used for tracking purposes so that a provider can readily verify the status of claims reviews and will be able to customize its address and point of contact for RAC correspondence.

7. Duration Of RAC Complex Reviews

RACs are required to make a medical review determination and notify the provider, within 60 days of receiving requested medical records, unless CMS has granted the RAC an extension of time to complete the review. RACs have two options in calculating the 60 day period: (1) applying the time period to each medical record individually, so each medical record would have an independent 60-day period associated with it; or, (2) the 60-day period does not start until all the medical records covered by a request are received by the RAC.

D. RAC Determinations

The RAC decision may deny payment of claims either partially (e.g. by down coding, or denying one line item on a multi-line claim) or in full. They must provide the specific reason for the denial. The RAC is required to document the rationale for the determination. This rationale should list the review findings including a description of the Medicare policy or rule hat was violated and a statement as to whether the violation (a) resulted in an overpayment or b) did not affect payment. The RAC may send only one review results letter per claim.

The RAC must notify providers of automated reviews only if they result in an overpayment. On the other hand, providers are entitled to be notified of the results of every complex review, including overpayments and underpayments and also those instances when no improper payment at all was identified. A copy of a sample RAC Notification of Improper Payment is attached as Exhibit "B".

E. Provider Rebuttal

The RAC letter advising the provider of an incorrect payment may offer the provider a short informal opportunity to rebut the findings. The time period to file the rebuttal is only 15 days and begins with the date of the letter. Delays in the mail system (weekends and holidays for example) can substantially reduce the period. The provider may submit any relevant argument and/or documentation to support its rebuttal.

Be aware, however, that the rebuttal is informal; it is not a prerequisite to any other appeal and it does not delay any other deadline or scheduled action. It is simply a vehicle that offers a relatively quick and inexpensive resolution in circumstances when there may be a short and ready answer to the issue raised by the RAC letter.

F. Appeals Process

A schematic drawing of the appeals process from Initial Determination to Federal Court is attached as Exhibit "C". It is the same process used for Medicare Claims Appeals, and is found at 42 CFR §405.900, *et seq*.

1. Initial Determination

The first decision, based on a RAC determination of improper payment, that is subject to the formal appeals process is the Denial Letter issued by the local contractor (i.e. carrier, fiscal intermediary or Medicare Administrative Contractor). This letter informs the provider of the reason for the denial and the calculation of the overpayment. The letter typically demands repayment of the overpayment within 30 days and advises that recoupment will begin in 40 days. See an example of a Denial letter attached as Exhibit "D". The letter also advises the provider of its appeal rights.

The initial demand letter also must offer the provider a fifteen day opportunity to submit a rebuttal. As with the RAC rebuttal process, this demand letter rebuttal is not a pre-requisite for a formal appeal. It does not alter the recoupment timeline and it does not prevent recoupment.

2. Staying Recoupment

Although the provider has 120 days from the date it receives the demand letter to file an appeal (at the first level termed a "Redetermination"), recoupment may start as early as the 30th day after the date of the Denial letter. In order to prevent the loss of funds under the recoupment process while the denial is being challenged, the provider should consider filing an appeal so that it is received by the RAC within 30 days. Even if there is time only for an abbreviated statement of the grounds for the appeal, the appeal should be filed and the Request for Redetermination can be supplemented later with further argument, information and/or documents.

If the request for Redetermination is filed later than the 30th day and the recoupment has started, the filing of the request will stop the recoupment from that point forward but will not result in amounts already recouped being paid back to the provider. Such repayment will be contingent on the final result of the appeals.

Note: The stay of recoupment lasts, at most, only during the first two levels of appeal – Redetermination and Reconsideration. The CMS contractor's authority to recoup is restored, at the latest, on the date of the QIC's decision on Reconsideration (the second level of appeal).

3. Interest

Interest begins accruing on the overpayment on the 31st day after the date of the demand letter, and continues accruing during any appeals that are filed. If the final result of the appeal process is that the government owes the provider money, then interest against the government commences on the date of the final administrative decision on the matter.

4. Redetermination (First Level Of Appeal)

a. Time for Filing Appeal

Requests for appeal must be filed within 120 days of receipt of the Denial Letter (Initial Determination). The address to send the Request is on the Denial letter. There is no amount in controversy requirement. CMS has provided a Form that may be used. The version current at the time this chapter was prepared is attached as Exhibit "E." The form is not required however, and providers should consider drafting their own Request. One benefit of writing your own request is that a Note to Stay Recoupment can be highlighted to ensure that the contractor takes appropriate action. (See Footnote 2, regarding CMS delay of implementation date of recoupment policy). A Model letter Request is attached

as Exhibit "F". The letter seeks Reconsideration but it easily can be modified to request a Redetermination. Whether using the CMS form or sending a letter, the appeal request must contain the following information:

1. the Beneficiaries name;

2. the Medicare health insurance claim ("HIC") number;

3. specific service(s) and /or item(s) for which the Redetermination is being requested and the specific date(s) of the service;

4. the name and signature of the party or the representative of the party;

5. the party must explain why it disagrees with the RAC's determination and should include any evidence that the party believes should be considered in the reconsideration.

If another party or parties file(s) a timely request for Redetermination before the first request has been decided then all the separate requests are consolidated into one proceeding and only one Redetermination decision is issued.

b. Late Filing of Request for Redetermination

If a Provider has missed the deadline for filing a request for Redetermination, the provider may still be able to pursue an out of time appeal if it requests an extension of time and the MAC finds that "good cause" for the late filing exists. The request for extension of time must satisfy the following requirements:

- be in writing;

- state the reason why the request was not filed within the required time frame and why those circumstance constitute "good cause" for the late filing;

- the request for extension of time must also contain all the required elements of a request for Redetermination set out above.

In determining whether "good cause" exists the MAC will consider:

- the circumstance that kept the party from making the request on time;

- if the contractor's action(s) misled the party; and

- if the party had or has any physical, mental, educational, or linguistic limitations, including any lack of facility with the English language, that prevented the party from filing a timely request or from understanding or knowing about the need to file a timely request.

Examples of "Good Cause":

- The party was prevented by serious illness form contacting the contractor in person, in writing, or through a friend, relative or other person; or
- The party had a death or serious illness in his or her immediate family; or
- Important records of the party were destroyed or damaged by fire or other accidental cause; or
- The contractor gave the party incorrect or incomplete information about when and how to request a redetermination; or
- The party did not receive notice of the determination or decision ; or
- The party sent the request to a Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired.

Best practice – file early and then supplement, rather than explain your "good cause" for being late.

c. Redetermination Decision Timeframe – No Escalation Right

The contractor must issue its decision on the Redetermination Request within 60 calendar days of the date it receives the Request for Redetermination. If a party submits additional evidence after filing its request, the timeframe for the contractor's decision is extended for 14 calendar days for each submission. If multiple parties file requests for Redetermination of the same claims then the contractor has 60 days from the latest timely filed Request to issue its decision.

Notably, the provider has no remedy, however, if the contractor does not issue its decision in a timely manner. Unlike later stages of the appeals process, there is no provision for escalation of the appeal to the next level if the contractor fails to meet the regulatory deadline for issuing its decision.

d. Redetermination Decision – Contents

The appeal is decided at this stage without an in-person hearing. The Contractor will issue its decision based on the written materials that have been submitted by the provider in its appeal and any information/documents from the RAC. The contractor adjudicates the claim(s) and affirms or reverses, in whole or in part, the initial determination in question. The decision must contain:

1. A clear statement indicating the extent to which the Redetermination is favorable or unfavorable;

2. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the Redetermination;

3. An explanation of how pertinent laws, regulations, coverage rules, and CMS policies apply to the facts of the case;

4. A summary of the rationale for the Redetermination in clear, understandable language;

5. Notification to the party of its right to the next level of appeal ("Reconsideration"), and a description of the procedures and timeframes the party must follow to obtain that level of appeal;

6. A statement of any specific missing documentation that must be submitted with a request for Reconsideration;

7. A statement that all evidence the party wishes to introduce during the remainder of the appeals process should be submitted with the request for Reconsideration;

8. Notification that evidence not submitted to the Qualified Independent Contractor ("QIC") at the Reconsideration level cannot be submitted at any later stage of appeal unless the provider can demonstrate good cause why the evidence was not previously submitted.

9. The procedures for obtaining additional information concerning the Redetermination decision, such as specific provisions of the policy, manual, or regulation used in making the determination.

5. Reconsideration (Second Level of Appeal)

a. Time for Filing

A request for reconsideration must be filed within 180 days of the date the provider receives the notice of Redetermination. The Request is considered filed on the date it is received by the Qualified Independent Contractor ("QIC"). There is no amount in controversy limitation on the right to reconsideration. The request must contain the same basic information as the request for Redetermination (see, above) and in addition include:

- the name of the contractor who made the Redetermination;

- any missing documentation identified in the Notice of Redetermination;

- evidence and allegations of fact or law related to the issue in dispute and an explanation which the provider disagrees with the Initial Determination, including the Redetermination.

CMS has provided a form for requesting Reconsideration and the version current at the time these materials were prepared is attached as Exhibit "G". CMS does not require the form to be used and providers may consider using their own letterhead to submit appeals to avoid the space constraints on the CMS form, which may invite an abbreviated explanation of the provider's position. See Exhibit "F" for an example of a letter request for Reconsideration.

b. Continuing the Stay of Recoupment

Although the provider has 180 days from the date it receives the notice of Redetermination to file a Request for Reconsideration, the CMS contractor may start recouping as early as the 60th day after the date of the Notice of Redetermination. In order to prevent the loss of funds under the recoupment process while appeals are still being pursued, the provider should consider filing a Request for Reconsideration so that it is received by the QIC within 60 days. Even if there is time only for an abbreviated statement of the grounds for the Reconsideration, the Request should be filed and it can be supplemented later with further argument, information and/or documents.

If the Request for Reconsideration is filed later than the 60th day and recoupment has started, the filing of the Request will stop the recoupment from that point forward but will not result in amounts already recouped being paid back to the provider. Such repayment will be contingent on the final result of the appeals.

Note: The stay of recoupment lasts, at most, only during the first two levels of appeal – Redetermination and Reconsideration. The CMS contractor's authority to recoup is restored, at the latest, on the date of the QIC's decision on Reconsideration (the second level of appeal).

c. Submission of Evidence (Last Opportunity)

Absent good cause, the failure to submit any item of evidence to the QIC before the Notice of Reconsideration is issued precludes consideration of that evidence at any subsequent level of the appeals process.

d. Request for Reconsideration - Late Filing

The same rules, including the rule of "good cause" that were discussed in regard to Requests for Redetermination apply to Requests for Reconsideration.

e. Reconsideration Decision – Timeframe - Escalation

Within 60 days of the date it receives the Request for Reconsideration, the QIC must issue notice of:

1. The Reconsideration Decision; or

2. Dismissal of the appeal: or

3. the QIC's inability to complete its review within the 60 day timeframe, and offer the provider the opportunity to escalate the appeal to the next level (the ALJ Level).

    a. If the provider wishes to escalate, it must notify the QIC in writing. If the Provider does not so notify the QIC, then the QIC continues to work on the Reconsideration and issues a decision on the Reconsideration. If the provider has chosen to escalate, then within 5 day s of receipt of the provider's notice (or 5 days from the end of the adjudication period) the QIC must:

        i. Complete its Reconsideration and issue its decision; or

        ii. Acknowledge the escalation notice in writing and forward the case file to the ALJ hearing office.

f. Reconsideration - Decision

There is not an in-person hearing at this level of appeal. The QIC renders its decision based on the written record. The decision has the same content requirements as the Redetermination decision and in addition includes:

- The notification that all evidence, including evidence requested in the Notice of Redetermination Decision, that was not submitted prior to issuance of the Reconsideration Decision will not be considered at the ALJ level, or made part of the administrative record, unless the provider establishes good cause why the evidence was not timely provided;

- A description of the provider's right to an ALJ hearing and the procedures to follow to obtain the ALJ hearing.

7. Expedited Access to Judicial Review

A provider may obtain expedited judicial review if it demonstrates that there are no material facts in dispute and the Medicare Appeals Council ("MAC") does not have the authority to decide the dispositive question of law or regulation, i.e. the

constitutionality of a statute, or the validity of a regulation or National Coverage Determination.

a. Time to File

The providers Request for expedited appeal must be filed anytime after the provider has filed a request for ALJ hearing, a request for MAC review or after an appeal has been escalated from the QIC to the ALJ level, but before the ALJ or MAC issues its decision. A provider can make only one such request as to a question of law for a specific matter in dispute in an appeal.

The ALJ or MAC has 60 days to review the request and issue a denial or a certification. If the ALJ or MAC does not act within that timeframe, then the provider may proceed to Federal Court and may bring an action within 60 days of the missed deadline.

b. Certification

If the appeal meets the requirements for expedited judicial review, the ALJ or MAC certifies in writing that:

1. the material facts involved in the claim are not in dispute;

2. the Secretary's interpretation of the law is not in dispute;

3. the sole issue(s) in dispute is the constitutionality of a statutory provision, or the validity of a regulation, CMS Ruling, or National Coverage Determination.

4. but for the provision challenged the requestor would receive a favorable decision on the ultimate issue; and

5. the certification by the ALJ or MAC is the Secretary's final action for purposes of seeking expedited judicial review.

8. ALJ Hearing (Third Level of Appeal)

a. Time for Filing

The hearing request must be filed within 60 days after receipt of the QIC decision or after the party has requested escalation from the QIC, under the procedures described above.

b. Amount in Controversy and Aggregation

Unlike the lower levels of appeal, a provider has a right to an ALJ hearing only if its appealed claims meet an amount in controversy minimum of $100.00 (after subtracting the deductible and copay amounts) as adjusted by the medical care component of the CPI for all urban consumers since 2003.

Either a single provider or multiple parties may aggregate two or more claims to meet the amount in controversy requirements, if

- the claims were previously Reconsidered by the QIC, or were pending before the QIC when the appeal was escalated;
- the request for ALJ hearing lists all of the claims to be aggregated, or the request for escalation listed all the claims to be aggregated;
- the ALJ determines that all the claims a single provider seeks to aggregate involve the delivery of similar or related services, or the claims sought to be aggregated by multiple parties involve common issues of law and fact.

c. Request for ALJ Hearing

The content requirements for the Request are the same as for the request for Redetermination and also include the document control number assigned to the QIC appeal; the reasons the provider disagrees with the QIC decision and a statement of any additional evidence to be submitted and the date it will be submitted. The provider filing the request must also send a copy to all others who were parties to the QIC appeal. CMS has also provided a form for requesting an ALJ hearing, and the version current at the time these materials were prepared is attached as Exhibit “H”. An example of a letter request for Reconsideration is attached as Exhibit “F”. It easily can be modified to be used as a Request for ALJ Hearing

d. No Stay of Recoupment

There is no stay of recoupment available from CMS during the last two levels of administrative appeal – ALJ Hearing and MAC Review.

e. The Hearing Before the ALJ

Unlike the proceedings at the lower levels of the process which are limited to a review of the written record, at the ALJ level a hearing is conducted unless waived by all parties to the ALJ proceedings. The hearing may be conducted in-person, by video-conference or by telephone. If the provider wishes to have an in-person hearing, it will have to show “good cause” why one of the other methods will not suffice. At the hearing, conducted by whatever method is chosen by the ALJ the parties may submit evidence

and the testimony of witnesses who are subject to cross examination by any other party and also subject to questioning by the ALJ.

Even if all parties to the proceeding waive the right to a hearing and request that a decision be issued based on the record alone, the ALJ may require the parties to appear at a hearing if s/he believes a hearing is necessary to decide the case.

f. Parties to ALJ Hearing - Participation of CMS

All parties to the QIC Reconsideration are parties to the ALJ hearing. CMS or its contractor, the RAC, may be a party to a hearing under the following circumstances:

- The ALJ requests, but cannot require, CMS or its contractor to participate,
- CMS and/or its contractor may elect to participate if it files a notice of its intent within 10 days of receiving the notice of hearing;
- CMS and/or contractor participation includes filing position papers or providing testimony to clarify factual or policy issues in a case but it does not include calling witnesses or cross-examining witnesses.

The ALJ will send a notice of hearing to all parties that filed an appeal or were parties to the QIC proceeding as well as to the contractor that issued the Initial Determination and to the QIC. The Notice will specify the time and place of the hearing.

g. Consolidated Hearing

The ALJ may hold a consolidated hearing if one or more of the issues to be considered are the same issues that are involved in another request for hearing pending before the same ALJ.

h. Discovery

Discovery is permissible only when CMS elects to participate in the hearing, and even in this situation it is limited:

- A party may request of another party the reasonable production of documents for inspection and copying;
- Depositions of another party are not permissible unless:
    - The proposed deponent agrees
    - The ALJ finds the deposition is necessary and appropriate in order to secure the deponent's testimony for an ALJ hearing.

- A party may not request admissions or send interrogatories or take any other form of discovery than is explicitly permitted under the ALJ Hearing rules.

i. Subpoenas

When it is reasonably necessary for the full presentation of a case, an ALJ may, on his/her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for a party to make books, records, correspondence, papers, or other documents that are material to an issue available for inspection and copying.

j. New Evidence

The ALJ will review all new evidence submitted by the provider and determine if the provider has good cause for submitting the evidence for the first time at the ALJ level. An example of "good cause" occurs when the new evidence is material to an issue addressed in the QIC's Reconsideration decision and that issue was not identified as a material issue prior to the QIC's decision.

k. Timeframe for ALJ Decision - Escalation

The ALJ has 90 days from the date of receipt of the hearing request to issue a decision, dismissal or remand to the QIC. If there is discovery permitted in the appeal then the time period for adjudication is tolled during the discovery period.

In appeals that are escalated to the ALJ from a QIC, the ALJ has 180 days to issue a decision. The ALJ's adjudication period begins when the request for escalation is received in the ALJ Hearing Office.

If an ALJ fails to issue a dismissal, remand or decision by the end of the adjudication period, the provider may request escalation of the appeal to the MAC under the same terms as discussed above in regard to escalation from a QIC to an ALJ hearing. If escalation occurs then the QIC decision becomes the final administrative decision for purposes of MAC review.

l. ALJ Decision

Unless the hearing request is dismissed (e.g. untimely request), the ALJ issues a written decision that gives findings of fact, conclusion of law and the reasons for the decision. The Notice of the Decision includes information on the right to appeal to the Medicare Appeals Council (MAC).

9. Medicare Appeals Council Review (Fourth Level of Appeal)

a. MAC Review Initiated

MAC review of an appeal is initiated when:

- A party to the ALJ Hearing requests review within 60 days after receipt of the ALJ decision or dismissal. Extensions of time may be requested under the terms discussed in regard to requests for Redeterminations.

- An appeal has been escalated from the ALJ to the MAC;

- The MAC, within 60 days of the ALJ decision, on its own initiative decides to review the ALJ decision.

- Within 60 days of an ALJ decision, CMS may refer it to the MAC and request the MAC to consider reviewing the decision.

A provider does not have a right to MAC review of an ALJ's remand to a QIC or an ALJ's affirmation of a QIC's dismissal of a request for reconsideration.

b. Request for Review - Contents

This request should have the same beneficiary, claim and service information as that required for Redetermination, discussed above, and the date of the ALJ's final action. The Request should also identify the parts of the ALJ decision with which the provider disagrees and the provider should explain why it disagrees with that portion. The MAC will limit its review only to those parts of the decision to which the provider has objected.

c. No Stay of Recoupment

There is no stay of recoupment available from CMS during the last two levels of administrative appeal – ALJ Hearing and MAC Review.

d. Evidence

The MAC generally limits its review of the evidence to that already contained in the record which includes a transcript of the ALJ hearing. There are a few exceptions:

- New Issue – If the ALJ hearing decision decides a new issue that the parties were not able to address at the ALJ level, the MAC will consider any evidence related to that issue submitted with the Request for MAC Review;

- MAC Discretion – If the MAC determines that additional evidence is needed to resolve the issues in the case and the hearing record indicates that previous

decision-makers did not attempt to obtain the evidence, the MAC may remand the case to the ALJ to obtain the evidence and issue a new decision;

- Issues Previously Considered by QIC – If new evidence is submitted that relates to issues previously considered by the QIC, the MAC will exclude the evidence unless it determines that the provider had good cause for submitting it for the first time at the MAC level.

e. Subpoenas

If the MAC decides it is necessary for the full presentation of a case, the MAC may, on its own motion or the request of a party , issue subpoenas requiring a party to make books, records, correspondence, papers or other documents available for inspection and copying.

f. Oral Argument

Either on its own initiative or the request of a party the MAC may order oral argument if it decides that the case raises an important issue of law, policy or fact that cannot readily be decided on the written submissions alone.

g. MAC Decision Timeframe – Escalation

The MAC must enter its decision within 90 days of its receipt of the request for MAC Review, or 180 days from receipt of the provider's request for escalation from an ALJ. If the MAC fails to meet the applicable deadline, then the provider may request escalation to Federal Court, under the procedures discussed above in regard to escalation from QICs.

G. Judicial Review

A party to a MAC decision, or an escalation from a MAC, may obtain judicial review in United States District Court if the amount in controversy is at least $1000.00 as adjusted by the CPI.

The case must be filed within 60 days of the MAC decision or within 60 days after the date the hospital receives notice that the MAC is not able to issue a final decision or remand within the prescribed time frame.

The law suit must be filed in the judicial district in which the provider resides or has its principal place of business.

H. Reopening

A reopening is a remedial action taken to change a final determination or decision hat resulted in either an overpayment or underpayment , even though the decision was correct based on the evidence then of record.

- A contractor can revise an initial determination or a redetermination;
- A QIC can revise a reconsideration
- An ALJ can revise a hearing decision
- The MAC can revise the hearing or review decision

However, when a party has filed an appeal of one of these decisions, no adjudicator has jurisdiction to reopen a claim until all appeal rights are exhausted.

1. Decision on Reopening is Final

The RAC's, contractor's, QIC's, ALJ's, or MAC's decision on whether to reopen is final and not subject to appeal.

2. Reopenings of Initial Determinations and Redeterminations

- On its own motion, a RAC may reopen initial determinations and a Contractor may reopen its own decisions:
    - Within one year for any reason
    - Within 4 years for good cause, (see below);
    - At any time if there is reliable evidence that the decision was procured through fraud or similar fault;
    - At any time to correct a clerical error on which the determination was based;
    - At any time to effectuate a decision issued under the coverage appeals process
- A party may request the RAC or contractor to reopen these decisions:
    - Within one year for any reason
    - Within 4 years for good cause, (see below)

- At any time to correct a clerical error on which the determination was based.

3. Reopenings of Reconsiderations, Hearing Decisions and Reviews

- A QIC , ALJ or MAC on its own motion may reopen its own decision
  - Within 180 days for good cause (See, below)
  - At any time if the decision was procured by fraud or similar fault
- A party may request the QIC, ALJ or MAC to reopen its own decision:
  - Within 180 days for good cause (See, below)

4. Good Cause for Reopening

a. Standards for "Good Cause"

"Good cause" may be established when:

- There is new and material evidence that:
  - Was not available or known at the time of the determination or decision; and
  - May result in a different conclusion, or
- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

b. Change in Law or Policy

A change in legal interpretation or policy in a regulation, ruling or general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening under the "good cause'" provision.

c. Third Party Payer Error

Good cause cannot be based on a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its records or on the claim form.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

A Note to Physicians and Providers from Medicare
Introducing The Recovery Audit Contractor (RAC) Demonstration

3/29/2007

FL

Dear Medicare Physician/Provider:

The Centers for Medicare & Medicaid Services (CMS), the federal Medicare agency, strives to pay claims accurately. The agency is committed to providing clear guidance on Medicare billing and payment policy. As part of CMS' further efforts to assure accurate payments the agency is now conducting a demonstration project using recovery audit companies. I believe the RAC Demonstration will provide CMS and taxpayers with information that will enable CMS to provide more educational efforts to providers which will result in improved processes for physicians, providers and their staff.

The recovery audit contractor will request medical records, review claims, and request adjustments for claims paid inaccurately.

The reason you are receiving this letter today is because the RAC has selected one or more of your claims for review. You have a responsibility to provide documentation supporting the claims as soon as possible. Failure to produce the information may result in the computation of an overpayment. Production of this information will not violate the Health Insurance Portability and Accountability Act (HIPAA).

Enclosed is a letter detailing the requested information and instructions for submitting medical records and documentation to the recovery audit contractor. Thank you for cooperating with us in this important demonstration.

Sincerely,

Gerald Walters

Gerald Walters
Director
Financial Services

HealthDataInsights

EXHIBIT "A"

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Recovery Audit Contractor Request for Medical Records

Request Date: 3/29/2007

FL

Dear

The Centers for Medicare & Medicaid Services ("CMS") has retained HealthDataInsights ("HDI") as a Recovery Audit Contractor ("RAC") to ensure the integrity of claims paid by Medicare in the State of Florida.

HDI has performed an automated review of claims and has identified claims which require further analysis.

This request for medical records/documentation is sent to you under a federally mandated program, section 306 of the Medicare Prescription Drug and Modernization Act of 2003 (MMA), which requires the Secretary of Health and Human Services to conduct a demonstration project using RACs to identify improper Medicare payments to healthcare providers. Providing medical records to HDI is within the scope of compliance of the Health Insurance Portability and Accountability Act (HIPAA).

We are requesting medical records/documentation regarding the claim(s) identified on the attached Records/Documentation Pull List (the "Pull List"). Also attached are instructions for submitting Records/Documentation. Please submit the documents specified on the Pull List along with the Pull List itself.

In order to expedite the receipt and processing of your medical records/documentation, please submit the information and Pull List immediately.

The records should be submitted within 45 days of the date of this letter. Upon receipt, our staff will review the documentation you submit for each claim to determine if the services billed are reasonable and necessary and meet all other requirements for Medicare coverage. Following our review, we will inform you in writing of our findings.

Thank you for your cooperation and prompt attention in this matter. If you have any questions, contact the HealthDataInsights office at 888-700-3282 ext 141.

Sincerely,

HealthDataInsights
Overpayment Investigations and Resolutions Department

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Sincerely,

HealthDataInsights
Overpayment Investigations and Resolutions Department

INOP-2041369

HealthDataInsights

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Instructions for Submitting Requested Medical Records

You may submit your medical records to HealthDataInsights one of two ways:

1. **FAX:**

FAX to: (702) 233-2167

Please adhere to the following directions when faxing:

- Send the record listed for each claim identified on the Records/Documentation Pull List as well as the Pull List itself.
- Please make sure all pages are complete, legible, and include both sides and page edge where applicable.

If you encounter any issues in faxing, please contact HDI at (888) 700-3282 Ext 141.

2. **MAIL:**

Mail medical record documentation to:
HealthDataInsights
2620 Regatta Dr.
Suite 208
Las Vegas, NV 89128

Please adhere to the following directions if you are mailing the requested information:

- Send the complete medical record listed on the claim identified on the Audit Detail.
- Photocopy each record. Please make sure all copies are complete and legible; include both sides of each page, including page edges.

If you have any questions regarding this request for medical records, please call HealthDataInsights (HDI) at (888) 700-3282 ext 141.

If the requested information is not received within the CMS time period, CMS and HDI will assume the services on the claim were not rendered and will pursue overpayment recoupment for these undocumented services.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CONFIDENTIAL

PULL LIST

Provider Name: _____

Audit ID: _____

Please submit records evidencing a qualifying 3 day inpatient hospital stay prior to the skilled nursing services. CMS' Common Working File does not contain verification of a qualifying 3 day inpatient stay

Patient: _____	Service Provider: _____	
DOB: _____		
Date of Service	Claim No	Medical Record #
		4696.78 853.96

Patient: _____	Service Provider: _____	
Date of Service	Claim No	Medical Record #
		11,759.40 3886.74

13

Please attach a copy of this Audit Detail to the Medical Records sent to HDI. Please reference the address and fax on the Instruction page.

HealthDataInsights

SP02-2041098

Page: 1

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

2/6/2008

SC

NOTICE OF INCORRECT PAYMENT DETERMINATION AND PENDING ADJUSTMENT HDI AUDIT ID

Dear

The Centers for Medicare & Medicaid Services ("CMS") has retained HealthDataInsights, Inc. ("HDI") as a Recovery Audit Contractor to ensure the integrity of the claims paid by Medicare for the purpose of identifying underpayments and overpayments.

HDI previously requested records from you for the services listed on the attached Audit Detail. Based on a thorough review of the records and other information you provided, HDI has concluded that its overpayment determination was accurate. Accordingly, HDI has therefore determined that an overpayment exists related to the claim.

Based on available information, we have determined that you had, or should have had, knowledge that the service(s) were not medically necessary and reasonable because of information contained in the Medicare Coverage Database, which may include applicable Local Coverage Decisions (LCDs) and Local Medical Review Policies (LMRPs).

A Local Coverage Determination (LCD), as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary- or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). LCDs consist only of "reasonable and necessary" information. LMRPs also contain category or statutory provisions.

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation, you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount.

HealthDataInsights

EXHIBIT "B"

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

You will receive a remittance notice from your fiscal intermediary reflecting the exact amount of the overpayment and withhold. If you disagree with the determination, you may submit a statement (including any pertinent information) within thirty days from the date of this letter as to why you believe the withhold should not be put into effect. You may fax any supporting documentation to 702-233-2167. We will review your documentation. However, this is not an appeal of the overpayment determination, and does not delay recoupment.

If you wish to appeal this decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive the remittance notice from your fiscal intermediary. Unless you show us otherwise, we assume you received the remittance notice 5 days after the date of the notice. Please send your request for redetermination to:

Palmetto GBA
Medicare Part A Appeals AG-630
2300 Springdale Drive
P.O. Box 100238
Columbia, SC 29202-3238

If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both CMS and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Thank you for your cooperation and prompt attention in responding to these audit results. If you have any questions regarding this letter, please call HealthDataInsights at 888-700-3282 ext 1141.

Sincerely,

HealthDataInsights
Overpayment Investigations and Resolutions Department

INC-2056882

HealthDataInsights

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CONFIDENTIAL

AUDIT DETAIL REPORT

Provider Name: [redacted]

Audit ID: _____

Patient:

Service Provider: _____

From Date	Thru Date	Claim No	Medical Record #	Audit Messages	Benefit Pai
				Inpatient should have been billed as Outpatient	22,915.(

Presentation on Admission:
69 M, Elective Outpatient admit for Biventricular ICD palcement.

Comorbidities/Coexisting Medical Condition
CHF, PVD with Necrotic toes on IV antibiotic and wound care, Hepatitis C with cirrhosis, CLL; HTN; A-fib; DM, and history of Cardiac arrest/ventricular tachycardia on Life-cor vest .

Evaluation/Treatment Period:
[redacted] AV synchronous biventricular pacing ventricular defibrillator implanted in L prepectoral pocket. PCU, O2 2 L, home meds. CXR-no report. [redacted] Mg=1.5, IV Mag x 1. Necrosis and maggots on toes. D/C Home with HHC to manage necrotic toes and F/U wound care.

Admission Denial:
No inpatient acuity documented; no complications post procedure or acute intervention; should have been Outpatient Surgery.

If you have any questions, please call HealthDataInsights at 888-700-3282 ext 1141

HealthDataInsights

RAC APPEALS PROCESS

Initial Determination
RAC Denial

↓

Redetermination
Fiscal Intermediary or Medicare Administrative Contractor

↓

Reconsideration
Qualified Independent Contractor (QIC)*

↓

Hearing
Administrative Law Judge (ALJ)*

↓

Review
Medicare Appeals Council (MAC) of Departmental Appeals Board (DAB)*

↓

Federal Court

* Provider can escalate to next level if reviewing entity fails to meet its deadline for deciding the appeal, (QIC – 60d; ALJ – 90d; MAC – 90d).

Exhibit C

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

URGENT - IMMEDIATE ATTENTION REQUIRED

1/24/2008

[redacted]

PLEASE IMMEDIATELY REFUND THE OVERPAYMENT OF [redacted] - AUDIT ID [redacted]

Dear [redacted]

The Centers for Medicare & Medicaid Services ("CMS") has retained HealthDataInsights ("HDI") as a Recovery Audit Contractor to ensure the integrity of claims paid by Medicare in the State of Florida for the purpose of identifying the underpayments and overpayments.

This letter is to notify you that you have received a Medicare payment in error, which has resulted in an overpayment to you of $[redacted]. The overpayment calculation and reason are listed on the attached Audit Detail and Refund Request.

Please remit your refund of [redacted] made payable to Medicare Part B to the address listed below by 2/23/2008 and no interest will be assessed.

IMPORTANT: Include the attached Audit Detail and Refund Request with your refund and REMIT REFUND TO:

First Coast Service Options
Attention: Medicare Part B Financial Services
PO Box 44039
Jacksonville, FL 32231-4039

Only those services or detailed lines within a claim that contain an overpayment are listed on the enclosed Audit Detail and Refund Request - the entire claim may not be listed. For your reference, the Audit Detail provides a short description of the identified overpayment.

If you do not refund within 30 days:

In accordance with 42 CFR 405.378 simple interest at the rate of 12.125% will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed for each full 30-day period that payment is not made on time. Thus, if payment is received 31 days from the date of this letter, one 30-day period of interest will be charged. Each payment will be applied first to accrued interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the rate of 12.125% per year.

AR Number(s)
[redacted]

HealthDataInsights

IN1-2061124

Exhibit D

We request that you refund this amount in full. If you are unable to refund the entire amount at this time, advise this office immediately so that we may determine if you are eligible for a repayment plan. Any repayment plan (where one is approved) would run from the date of this letter.

If payment is not received by 3/4/2008, payments to you will be withheld until payment in full is received, an acceptable extended repayment request is received, or a valid and timely appeal is received. If you have reason to believe that the withhold should not occur on 3/4/2008, then you must notify HDI before 3/4/2008. You may fax any supporting documentation to (702) 233-2167. We will review your documentation. However, this is not an appeal of the overpayment determination, and it will not delay recoupment.

If you wish to appeal this decision:

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The first level of appeal is called a redetermination. You must file your request for a redetermination within 120 days of the date you receive this letter. Unless you show us otherwise, we assume you received this letter 5 days after the date of this letter. Please send your request for redetermination to:

First Coast Service Options
Attention: Overpayment Redeterminations (Review) Requests
PO Box 45248
Jacksonville, FL 32232-5248

If you have filed a bankruptcy petition:

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both CMS and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Thank you for your cooperation and prompt attention in responding to these audit results. If you have any questions regarding this letter, please call HealthDataInsights at (800) 946-5558.

Sincerely,

HealthDataInsights
Overpayment Investigations and Resolutions Department

AR Number(s) [redacted]

IN1-2061124

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

_____

_____

_____

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

_____

_____

_____

7. Additional Information Medicare Should Consider: _____

_____

_____

_____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

_____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. ❑ I have evidence to submit. (Attach such evidence to this form.)
❑ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Exhibit E

[DATE]

VIA FEDERAL EXPRESS

MAXIMUS Federal Services, Inc.
QIC Part A East Project
1040 First Avenue, Suite 400
King of Prussia, PA 19406

Re: REQUEST FOR RECONSIDERATION
Provider:
Beneficiary:
HICN:
ICN:
Dates of Service:
Services Denied:

To Whom It May Concern:

The Beneficiary and _____ ("Provider") the Provider, as parties to a partially adverse redetermination by _____ (the "Intermediary") for the above-referenced claim, request a reconsideration of the denial in accordance with 42 C.F.R. § 405.960 et seq. We assert that this redetermination was erroneous in part because it was based upon a flawed analysis of the clinical evidence. This request is filed within 180 days from the date the Medicare Redetermination Decision letter dated _____("Decision") was received by the parties. All records, information, documentation and evidence submitted to the Intermediary are incorporated by reference in this Request for Reconsideration.

Please note that we are submitting evidence, facts and legal authorities to document the medical necessity of the claim. We expressly reserve the right to supplement this Request for Reconsideration and the record before the QIC with additional records, information, documentation and evidence. We request that a decision not be issued until after the QIC has been notified that all evidence has been submitted.

In accordance with the requirements of the Medicare Modernization Act, no recoupment of funds should occur pending the outcome of the reconsideration and any subsequent levels of the appeals process. (See, 42 U.S.C. § 1395ddd(f)(2)(A)).

I. THE REDETERMINATION

[Explanation of the Redetermination Decision]

II. MEDICAL HISTORY

General History

III. ARGUMENT AND CITATION OF AUTHORITY

For the following reasons the denial must be reversed and the claim fully reimbursed.

[ARGUMENTS INCLUDE THE STANDARDS FOR REIMBURSEMENT AND HOW THE BENEFICIARY MET THE STANDARDS -- A SAMPLE ARGUMENT IS REPRODUCED BELOW]

A. The Documentation Supports the Medical Necessity of the Services Provided

1. The Therapy Services Were Ordered By the Beneficiary's Treating Physician

As a threshold matter, the services were provided as ordered by the Beneficiary's treating physician.

The physician's order was not given sufficient deference by the reviewers. According to the "treating physician rule," the treating physician's opinion on the diagnosis, nature and degree of impairment and treatment is: (1) binding on the fact finder unless contradicted by substantial evidence; and (2) entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a beneficiary's medical condition than are other sources. Schisler v Bowen, 851 F.2d 43 (2nd Cir. 1998). *See also*, State of New York v. Sullivan, 927 F.2d 57 (2nd Cir. 1991); Pfalzgraf v. Shalala, 997 F.Supp. 360 (WDNY 1998); see also Smith o/b/o McDonald v. Shalala, 855 F.Supp. 658 (D. Vt. 1994) ("the Secretary is expected to place significant reliance on the informed opinion of a treating physician"); Kiernan v. Shalala, 5:91-CV-58 (D. Conn. July 11, 1994) (ALJ's findings that the subject services could have been rendered more effectively in a less intensive setting were reversed because the ALJ was required to give heightened attention to the opinion of the beneficiary's treating physician or to offer a reasoned basis for declining to do so).

Here, it was the Beneficiary's physician, not the reviewers, who (1) had contact with Beneficiary; (2) had access to her medical record and past history; (3) spoke with the Beneficiary and her family; (4) observed the Beneficiary; (5) participated in her care plan; and (6) made medical judgments based on the circumstances for this Beneficiary. The Beneficiary's physician was more familiar with her condition and determined that she should continue to receive the

intervention of skilled therapists throughout the period at issue. As such, it is this determination that is owed deference in reviewing the claims.

[INSERT ADDITIONAL ARGUMENTS AS APPROPRIATE]]

All records, information, documentation and evidence submitted to the Intermediary are incorporated by reference in this Request for Reconsideration.

CONCLUSION

For the above reasons, we request reversal of the denials for the rehabilitation services provided. Thank you for your consideration.

Sincerely,

PROVIDER

Enclosure

cc: [FOLLOW INSTRUCTIONS ON REDETERMINATION LETTER REGARDING WHO RECEIVES COPIES OF REQUEST FOR QIC REVIEW]
[COPY MAC/FI REPRESENTATIVE SO THAT YOU RECEIVE THE STAY OF RECOUPMENT WHILE THE APPEAL IS PENDING]

EXHIBITS

1. Appointment of Representative Letter
2. Supplemental Medical Records
3. Medicare Redetermination Decisions (January 7, 2008)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

_____

_____

_____

6. Date of the redetermination notice _____
(If you received your redetermination more than 180 days ago, include your reason for not making this request earlier.)

_____

_____

_____

7. Additional Information Medicare Should Consider: _____

_____

_____

_____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

_____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. ❑ I have evidence to submit. (Attach such evidence to this form.)
    ❑ I do not have evidence to submit.
15. Name of the Medicare Contractor that Made the Redetermination: _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20033 (05/05) EF (05/2005)

Exhibit G

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

❑ Part A
❑ Part B

Effective July 1, 2005. For use by party to a reconsideration determination issued by a Qualified Independent Contractor (QIC)
(Amount in controversy must be $100 or more.)

Send copies of this completed form to:
Original *— Office of Medicare Hearings and Appeals Field Office specified in the QIC Reconsideration Notice*
Copy *— Appellant* ***Copy*** *— All other parties*
Failure to send a copy of this completed request to the other parties to the appeal will delay the start date of your appeal.
Did you send all required copies? ❑ Yes ❑ No

Appellant *(The party appealing the reconsideration determination)*

Beneficiary *(Leave blank if same as the appellant.)*			Provider or Supplier *(Leave blank if same as the appellant.)*		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Area Code/Telephone Number	E-mail Address		Area Code/Telephone Number	E-mail Address	
Health Insurance (Medicare) Claim Number			Document control number assigned by the QIC		
QIC that made the reconsideration determination			Dates of Service From	To	

Verify current version at www.cms.hhs.gov/cmsforms/cmsforms

I DISAGREE WITH THE DETERMINATION MADE ON MY APPEAL BECAUSE:

You have a right to be represented at the hearing. If you are not represented but would like to be, your Office of Medicare Hearings and Appeals Field Office will give you a list of legal referral and service organizations. *(If you are represented and have not already done so, complete form CMS-1696.)*

Check **Only One** Statement:	❑ I **wish** to have a hearing. ❑ I **do not wish** to have a hearing and I request that a decision be made on the basis of the evidence in my case. *(Complete form HHS-723, "Waiver of Right to an ALJ Hearing.")*	Check **Only One** Statement:	❑ I **have** additional evidence to submit. ❑ I **have no** additional evidence to submit. If you have additional evidence to submit, please attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it. If you are a provider, supplier, or beneficiary represented by a provider or supplier, the evidence must be accompanied by a good cause statement explaining why the evidence is being submitted for the first time at the ALJ level.

The appellant should complete No. 1 and the representative, if any, should complete No. 2. If a representative is not present to sign, print his or her name in No. 2. Where applicable, check to indicate if appellant will accompany the representative at the hearing. ❑ Yes ❑ No

1. (Appellant's Signature)		Date	**2.** (Representative's Signature/Name)		Date
Address			Address		❑ Attorney ❑ Non-Attorney
City	State	Zip Code	City	State	Zip Code
Area Code/Telephone Number	E-mail Address		Area Code/Telephone Number	E-mail Address	

Answer the following questions that apply:
A) Does request involve multiple claims? (If yes, a list of all the claims must be attached.) ❑ Yes ❑ No
B) Does request involve multiple beneficiaries? (If yes, a list of beneficiaries, their HICNs and the dates of service.) ❑ Yes ❑ No
C) Did the beneficiary assign his or her appeal rights to you as the provider/supplier? ❑ Yes ❑ No
(If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment.)

Must be completed by the provider/supplier if representing the beneficiary:

I waive my rights to charge and collect a fee for representing _____ before the Office of Medicare Hearings and Appeals.
(Beneficiary name)

Signature of provider/supplier representing beneficiary	Date

CMS-20034 A/B U3 (08/05) EF 08/2005 ATTACH A COPY OF THE RECONSIDERATION DETERMINATION (IF AVAILABLE) TO THIS COPY.

Exhibit H

Must be completed by the provider/supplier if representing the beneficiary, they furnished the item(s) or services(s) at issue, and the appeal involves a question of liability under section 1879(a)(2) of the Social Security Act:

I waive my right to collect payment from the beneficiary for the furnished items or services at issue involving 1879(a)(2) of the Social Security Act.

Signature of provider/supplier representing beneficiary	Date

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS

Is this request filed timely? ❑ Yes ❑ No

If no, attach appellant's explanation for delay. If there is no explanation, send a Notice of Late Filing of Request for ALJ Hearing to the appellant and representative, if applicable, to request such an explanation.

Request received on	Field Office	Employee
Assigned on	Assigned by	Assigned to

Special response case? ❑ Yes ❑ No

If yes, explain why and state the targeted adjudication deadline.

Interpreter/translator needed (including sign language) ❑ Yes ❑ No

If yes, type needed:

If appellant not represented, has a list of legal referral and service organizations been provided? ❑ Yes ❑ No

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

Appendix L

Provider Appeals

Table JUL1: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs only, Part A claims only

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider (all levels)	% favorable to provider (all levels)	% of all claims overturned on appeal
Connolly	78,698	6,608	1,067	73	18	7,766	9.9%	4,007	51.6%	5.1%
HDI	104,394	24,318	6,053	556	7	30,934	29.6%	11,658	37.7%	11.2%
PRG	91,860	11,868	3,410	1,380	172	16,830	18.3%	2,478	14.7%	2.7%
RAC not known[1]	n/a	0	1,018	201	0	1,219	n/a	443	36.3%	n/a
All RACs	274,952	42,794	11,548	2,210	197	56,749	20.6%	18,586	32.8%	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 8/31/08. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

[1] This table includes 1,219 Part A appeals that cannot be attributed to a specific RAC. See page four for more details.

Exhibit I

CHAPTER 7:

POST ACUTE / REHAB HOSPITALS / SNFs / OUTPATIENT REHAB / LTACHs

AUTHORS:

Jane Snecincki – Chair	**Noblis**
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RECOVERY AUDIT CONTRACTOR (RAC) READINESS MANUAL
POST-ACUTE CARE

TABLE OF CONTENTS

Introduction

As previous chapters have discussed, the mission of the Recovery Audit Contractor (RAC) demonstration project (announced January 11, 2005) was to "reduce Medicare improper payments through the efficient detection and collection of overpayments and underpayments and the implementation of actions that will prevent future improper payments".[1] Since the scope of Medicare services is so broad, post acute providers, specifically inpatient rehabilitation, outpatient rehabilitation and skilled nursing, were included in the efforts of the RACs to fulfill their mission statement. As with all Medicare providers, improper payments in the post acute settings can be received for three primary reasons:

- Services are provided and payment received for services that have not been deemed as 'medically necessary' for the level of care in which they were provided;
- Codes/scores are submitted that result in payment that may not be completely correct or accurate, e.g., inaccurate diagnostic coding, inaccurate coding of functional status, coding of diagnoses without documentation of treatment, etc.
- The medical record/documentation does not 'tell the story' and provide enough support for the claim for which payment has been received. [2]

While the issues are the same for all Medicare providers, the regulatory basis and documentation of care necessary for proper payments in the post acute setting must address different issues than other providers. The understanding of these issues is critical to surviving under the permanent RAC program, and hopefully, will lead to proactive steps to eliminate causes for RAC denials.

This section of the GHA Recovery Audit Contractors (RACs) Readiness Manual will focus on the post acute settings to provide a baseline understanding of the framework for potential RAC denials and what can be done to prevent or, at a minimum, decrease the risk of potential RAC denials.

Background

The RACs in the demonstration states identified errors in payment in three levels of post acute care: inpatient rehabilitation (California), outpatient therapy (Florida and New York) and skilled nursing facilities (California). The percentage of errors in these three settings was not a significant percentage of the total overpayments collected by providers (approximately 8 – 10% of the total). When considering the total amount of overpayments, the amount identified in the post acute providers does not seem that significant (just over $76 M).

When the post acute provider is part of a larger acute care entity, their impact may only be a small part of the overall operational pie. But, for post acute providers in the demonstration project, the dollar amount was significant. The Centers for Medicare and

[1] www.cms.hhs.gov/RAC/05_MissionStatement.asp

[2] The Medicare RAC Program: An Evaluation of the 3-Year Demonstration, June, 2008

Medicaid Services (CMS) reported that only 14% of the overall RAC determinations had been appealed and only 4.6 of those had been overturned in the appeal process.[3] However, individual post acute providers have reported that the impact of the RAC was significant for them and the amount of time spent in the appeal process was excessive. One administrator of an inpatient rehabilitation provider indicated they were spending 100%+ of their time "handling" the appeals. The providers also report that they had a high success rate of appealing the denials, but most of that success was the result of taking the appeal process to the level of the Administrative Law Judge (ALJ) review. Due to the time frames of the appeal process discussed earlier in this Manual, one can see how the time spent in the appeal process could result in significant cash flow issues. And many providers reported a change in operations for fear of RAC review, regardless of their surety that the patients were appropriate for admissions and subsequent billing.

For all of the improper payments, the key component in the review was the medical record. In order to reduce the risks of a potential RAC review, it is critical that all post acute providers are proactive in identifying and determining what a review would reveal, prior to the actual review occurring. In other words, ongoing audits and reviews of the medical record will identify weaknesses in the reliability, validity, accuracy and completeness of the medical record and give the provider a chance to identify the issues, develop a corrective action, and implement all changes as quickly as possible. For post acute providers, it is important that these internal audits and reviews be conducted by individuals with the expertise to identify potential issues.

It is also important to remember that once the record is open for review, the whole content is subject to scrutiny. For example, if an outpatient therapy record is requested for review of the support for the treating diagnosis, and it is determined that individual therapy is charged when group therapy was provided, an improper payment is identified. If an inpatient rehabilitation record is requested for review of the support for the medical necessity of the admission of a joint replacement patient and medical necessity is supported but it is determined that inaccurate payment was received due to inaccurate scoring on the Patient Assessment Instrument, an improper payment is identified. And if a skilled nursing facility record is requested for review of the medical necessity of therapy services, and it is determined that the RUG was assigned with an inaccurate count of therapy minutes, an improper payment is identified.

[3] The Medicare Recovery Audit Contractor (RAC) program: An Evaluation of the 3-Year Demonstration, June, 2008.

Inpatient Rehabilitation

Impact of RAC Review and Discussion

The RAC demonstration project resulted in the identification of approximately $1.03 billion in improper payments (actual figures vary slightly based on source). Of that amount, $59.7 million or 6% of the total was identified from inpatient rehabilitation providers. (These figures represent the dollar amounts without adjustment for successful appeal processes.) The efforts focusing on inpatient rehabilitation providers did not take place in all three RAC demonstration states, but only in California. The most recent evaluation of the demonstration project reports: "The RAC demonstration had a limited financial impact on most providers", however this was clearly not the case for the inpatient rehabilitation providers in California. Moreover, even an informal extrapolation to all of the fifty states will provide the reader with the potential impact of these denials on a larger scale.

The following table depicts the circumstances, or noted errors that resulted in the improper payments.

***Overpayments Collected by Error and Provider Type** (1)*

Error Type	*Percent of Total*
Medically Unnecessary	5.63
Incorrectly Coded	0.00
No/Insufficient Documentation	0.44
Other	0.00
Total	**6.07**

(1) Cumulative through 3/27/08;

Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-year Demonstration, June, 2008

When considering the error type, it is clear that the comprehensiveness and accuracy of the documentation of the patient's stay in an inpatient rehabilitation program is a key factor in the denial process; that is, the ability of the medical record to "tell the story" and demonstrate, without a doubt, that the patient required an admission to an inpatient rehabilitation program to care for their medical and rehabilitation needs, and that the diagnoses identified were treated during the hospital stay.

Medical Necessity

There is no standardized definition or interpretation of 'medical necessity', which leads to confusion as to the necessary content of medical record documentation. However, it is important to keep in mind that inpatient rehabilitation beds are licensed as acute care beds

and certified by Medicare as inpatient rehabilitation beds. Therefore, it is important to demonstrate that the patients have a medical condition(s) that, in conjunction with their needs for an intensive, inpatient rehabilitation program, require admission to a licensed acute care bed that has been Medicare certified as a 'rehabilitation bed'. If a patient does not exhibit the medical needs or does not need, cannot tolerate, or could make as much progress from another level of care, then it is the perception of the RAC that the patient could be admitted to another level of care and medical necessity for inpatient rehabilitation is not demonstrated.

When describing medical necessity for inpatient rehabilitation, all sources refer to the Medicare Beneficiary Manual, Chapter 1, Section 110, Inpatient Stays for Rehabilitation Care. In this chapter the following caveats are provided:

- "the services must be reasonable and necessary (in terms of efficacy, duration, frequency and amount) for the treatment of the patient's condition; and
- 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, on an outpatient basis".[4]

One of the largest populations in question from the RAC demonstration project were those patients who underwent single joint replacements. Many of these patients are discharged from acute care in a medically stable condition and most do require physical and occupational therapy. However, often those disciplines struggle to find a need for an intensive therapy program (three hours of therapy) and will report "running out of things to do". In this example, questions relating the admission as a result of either of the above quoted reasons may be valid. Unless a specific joint replacement patient's condition is documented as significantly unique with clear explanations of the necessity of their condition or treatment, then it appears that the question of medical necessity could be raised.

In order for the admission to be medically necessary, patients admitted to an exempt inpatient rehabilitation program must require and receive care as described in Medicare Beneficiary Manual, Chapter 1, Section 110. There are several components in the chapter that note if a particular component *in isolation* was not provided, that, in and of itself, would not be justification of denying payment. However, while the RAC identification of improper payment for 'medical necessity' did not identify specific components of the referenced chapter as not having been demonstrated, it stands to reason that when documentation does not support several of the components, medical necessity may be questioned.

What is interesting to note is that while most inpatient rehabilitation providers know these conditions very well, they have not internalized them into practice within their delivery of care. Therefore, the documentation of the patient's care is unlikely to focus on the issues to demonstrate the medical necessity as described in the Manual Chapter. It

[4] Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered Under Part A, "Inpatient Stays for Rehabilitation Care"

is this situation that places an inpatient rehabilitation provider at risk under the RAC program.

Each of the conditions identified in the inpatient rehabilitation information from the Medicare Beneficiary Manual will be briefly discussed with common mistakes of inpatient rehabilitation providers, a follows:

Preadmission Screening – It is standard operating practice for inpatient rehabilitation providers to perform a preadmission assessment/screening of each patient with the purpose to determine the appropriateness of the admission to the inpatient rehabilitation setting. While this process and associated documentation is an optimal place to begin the discussion and justification of the medical necessity of admission, many organizations just reiterate patient, diagnostic, and clinical information from the acute medical record. The purpose and documentation of the preadmission screening process, therefore, should not only be to provide information important to the decision-making process, but also to clearly identify the reasons to admit a patient and the need for treatment, e.g., start the justification for why the patient has to be admitted to an inpatient rehabilitation program versus any other level of care.

SUGGESTIONS:

1. There are significant references in Medicare regulations to the decision to admit a patient being based on a physician determination of what justifies the admission. A strong way to initially demonstrate the medical necessity of the admission is to have written verification of the physician decision to admit the patient and the reasons that the inpatient rehab stay is needed (vs. any other level of care).
2. Ensure the preadmission screening form is part of the inpatient rehabilitation medical record.
3. Consider including copies of any consulting reports or progress notes from acute care that would support admission to the inpatient rehabilitation program as an attachment.
4. Ensure information about the benefit of the admission for the patient's expected outcome (i.e. physical/functional outcome and medical/surgical recovery) is addressed on the prescreening form.
5. Include discussion of the patient's expected gains as a result of participation in the program as well as an estimated length of stay. (See *Realistic Goals* and *Significant Practical Improvement* herein.)
6. If the preadmission screening documentation is a form/template, ensure that the form/ template is complete.

Admission Orders – Admission orders to the inpatient rehabilitation program and ongoing modification of those orders is, once again, standard operating practice. Many orders, however, address the treatment/plan of care in generalities. For example, physical and occupational therapy and speech language pathology may be ordered as "evaluate and treat". It is important to remember that therapy evaluation and treatment can be provided in many levels of care, not only an inpatient rehabilitation setting.

SUGGESTIONS:

1. Ensure the admission orders, as well as all subsequent orders, support the medical needs/care of the patient and the intensity of therapeutic services as defined in this Chapter.
2. If the plan of care is developed following the assessment of the patient by all disciplines, refer to that in the admission orders and ensure subsequent orders reflect the recommendations of the interdisciplinary treatment team.

Note: The physician admission documentation is critically important. This documentation not only includes the orders, but also includes the comprehensive H&P (addressing each of the eight admission criteria).

Inpatient Assessment of Individual's Status and Potential for Rehabilitation – This section of the Chapter discusses the completion of the Patient Assessment Instrument (PAI) and provides direction for completion and submission of the PAI. Keeping in mind that the PAI reflects the patient's medical diagnosis and functional status upon admission (and therefore a reimbursement category, the Case Mix Group (CMG) is established) the functional independence measurement (FIM) scores on the PAI should support the medical necessity of the admission. For example, if a patient is admitted at "minimal assistance" or "supervision" level for all functional areas with the exception of ambulation and stairs, a question may be raised as to why the care could not be provided in another setting, e.g., home health care or a skilled nursing facility.

To date, there has been no documentation of a RAC identifying an improper payment due to inaccurate scoring on the PAI. However, keeping the mission of the RAC in mind, it only stands to reason that this may be an area of future interest. For example, consider the situation where scores being are submitted on the PAI that depict the patient as being more dependent than the patient truly is due to inaccurate scoring methodologies. This would result in an overpayment for the provider.

SUGGESTIONS:

1. Ensure that the PAI is being scored accurately based on staff competency to do so. Documentation in the record should support the score submitted on the PAI.
2. Include the patient's functional status in the decision-making process to admit a patient.
3. If a patient is admitted at a relatively high functional status and the admission is deemed appropriate, ensure that documentation clearly supports the patient's potential rehab progress and medical documentation supports medical necessity rationale.

In this section of the Chapter, there is also information on a patient being admitted for an assessment for admission. While this type of admission is most likely the exception rather than the rule, understanding of this section will be of assistance to structure documentation to support the need to provide this assessment on an inpatient basis.

Close Medical Supervision by a Physician With specialized Training or Experience in Rehabilitation – The majority of inpatient rehabilitation providers have a medical director for the inpatient rehabilitation program, per *42 CFR Part 412.23(b)(5) and 42 CFR, Part 412.29(f)* and therefore partially meet this criteria. However, this criteria also instructs that the progress notes in the medical record need to demonstrate the medical necessity of the physician involvement in the patient's care. If internal audits were to occur in most inpatient rehabilitation programs focusing on the content of the (rehab) physician's progress notes, the results would most likely be a cause for concern. This concern is magnified when considering the work of the RACs since it is the physician who would be the champion for demonstrating the medical necessity of the admission. For example, many physicians' notes are not legible. When they are legible and often when they use a computerized template, the information is duplicative from day to day. Many notes reflect verbiage such as "patient is progressing well. Continue program." These examples are problematic when focusing on demonstrating the medical necessity of the admission. Also, many physicians see the patient daily, with the above content in their notes. This content does not support the frequency of a daily visit.

SUGGESTIONS:

1. Focus the content of the (legible) rehab physician's note on the need for their involvement with the patient that specific day, progress made, modifications to plan of care, order changes, medical interventions, and active co-morbid conditions requiring treatment and intervention., etc.
2. When templates or electronic documentation is utilized, eliminate as many 'cut and paste' capabilities as possible and create cues for the physician to document the medical necessity of their visit and the ongoing stay in the inpatient rehabilitation unit.
3. Physicians should document how medical and co-morbid conditions impact therapy participation, tolerance, and progress.
4. Encourage physicians to document their involvement with the team which will be helpful in supporting the medical necessity of their visit.

Rehabilitation Nursing – Currently, the demand for nursing exceeds the supply, while simultaneously the number of certified rehabilitation nurses is declining. In order to meet this criteria, the provider should either ensure that there are registered nurses (RN) on staff who are certified or the nursing staff for the inpatient rehabilitation program has received training and/or education in "rehabilitation" nursing instead of med/surg nursing alone. These 'rehab nurses' need to document that (functional) rehabilitation nursing has been provided in additional to medical nursing and they have worked as an integral member of the interdisciplinary team. Patient access to this type of nursing expertise is needed and required 24/7. The training and education could be obtained either on an internal or external basis and the expertise could be verified through the assessment of established competencies assessed on a periodic basis.

In many organizations, the inpatient rehabilitation program is using nursing documentation (manual or electronic) that has been developed to reflect the provision of med/surg nursing. It is important that all documentation of nursing provides the opportunity to demonstrate the involvement of the rehabilitation nursing in the care of the patient, and the medical necessity of that involvement. For example, if there is no difference in the documentation provided by RNs on a med/surg unit and those who staff the inpatient rehabilitation program, a question may be raised as to the provision of rehabilitation nursing. In addition, if the patient makes progress without the documented involvement of rehabilitation nursing, a question could be raised as to why the treatment could not have been provided in another level of care.

SUGGESTIONS:

1. Clarify the definition of rehabilitation nursing in your inpatient rehabilitation program and how the provision of rehabilitation nursing is demonstrated as part of the care provided.
2. Identify the ways that the provision of rehabilitation nursing is documented. More effective documentation may occur if the templates and/or forms used cue the nursing staff to document components of rehabilitation nursing, vs. having the expectation that a narrative note may reflect rehabilitation nursing.
3. Create a documentation system where the rehabilitation nursing note is tied into the scoring of a functional area for the PAI.
4. Have the physician's orders and progress notes discuss the medical necessity of rehabilitation nursing and the components of care to be provided.
5. Ensure the documentation of the team conference reflects a discussion involving rehabilitation nursing as part of the treatment team, for medical/surgical conditions as well as reinforcing therapy lessons and techniques.

Relatively Intense Level of Rehabilitation Services - This criteria of care has a long history of being known as the "3 hour rule". It is important to keep in mind that as a result of the patient's medical issues, they may not be able to receive three hours of therapy for a minimum of five days a week. However, aside from medical issues, when a patient does not receive this intensity of therapy, the cause may often be staffing issues. Some examples of such staffing issues include: a lack of therapy coverage on weekends, a shortage of therapy staff to provide this amount of therapy, the patient's condition does not require this intensity of therapy, the patient could participate but chooses not to participate, staff is scheduled to work at times that the patients are not available to be scheduled for and receive therapy, etc.

The provision of therapy refers to the treatment of the patient, that is, the time the patient is receiving treatment exclusive of set up time, rest periods, documentation time, etc. It is important to keep in mind that the reimbursement system for skilled nursing facilities provides the highest reimbursement for patients who receive therapy, but not the intensity of therapy identified for inpatient rehabilitation. Therefore, if any of these situations occur, and the patient continues to make progress, a question of medical necessity could be raised as to why the care could not have been provided in a skilled nursing facility. However, if the patient receives and benefits from a lower intensity of therapy at the

same time as a medical condition is being treated, the medical necessity for admission to an inpatient rehabilitation program may be justified.

The patient's needs for therapy have to require skilled therapy services which may not be clear if there is notation of decreased strength and endurance, debility, deconditioning, etc. Often there are very important therapeutic goals that require skilled therapy services that go unstated when the above conditions are noted. Documentation of this intense level of provision of therapy should clearly reflect:

- The patient's conditions clearly require skilled therapy services;
- The patient needs, is provided, and benefits from this intensity of therapy; and
- The intensive therapy was scheduled at times that met the patient's needs vs. staff convenience.
- Services provided are directly linked to achievement of functional goals.

If the patient does not have active treatment goals for skilled therapy services or there is a lack of demonstration that ongoing progress is being made, then, once again, a question may be raised as to why this care could not have been provided in another level of care.

There has been some evidence of improper payments being identified due to a significant percentage of therapy in inpatient rehabilitation programs being provided in group settings. It is noted that the criteria does not say "one on one" therapy, but does refer to "intensive" therapy. Furthermore, there is no guidance from the Center for Medicare and Medicaid Services (CMS) regarding group therapy in inpatient rehabilitation. However, there is CMS guidance regarding the amount of group therapy that can be provided in a skilled nursing facility, 25%. Therefore, if CMS refers to "intensive" therapy, it may suggest that there should not be more group therapy in inpatient rehabilitation than in a skilled nursing facility.

This criteria is perhaps the one that the majority of inpatient rehabilitation providers know very well, and yet may not demonstrate the provision of this criteria in day to day operations. In other words, management and staff can verbalize the criteria but continue to provide an intensity of therapy that is less than three hours of therapy for five days/week.

SUGGESTIONS:

1. Ensure therapy staffing can support the provision of three hours of therapy for a minimum of five days a week as supported by documented treatment time.
2. Ensure therapy documentation captures the amount of hands on treatment provided.
3. Create at least a periodic audit tool to verify the intensity of service being provided, taking corrective actions as needed.

Multi-Disciplinary Team Approach to Delivery of Program* and *Coordinated Program of Care The team conference process has long been a cornerstone of inpatient rehabilitation programs and has been the primary mechanism for the team to coordinate care and to reflect the team approach to care. It is important to note that the team, as identified in this criterion, has been defined to include a physician, rehabilitation nurse,

social worker and/or psychologist and therapist, who meet at least every two weeks. In most organizations, a weekly team conference is documented which would be appropriate with the current average lengths of stay in an inpatient rehabilitation program. On occasion, all of the members of the team, as identified, are not involved. Furthermore, in many cases, either the team conference process or documentation of the team conference reflects reports from single disciplines as opposed to a team discussion to the care – a team approach. The criterion specifically addresses the focus of the team conference and the type of discussion that should be taking place and documented. Without documentation of this team approach, it can be assumed that the care could be provided in another level of care.

SUGGESTIONS:

1. Ensure all of the identified team members attend and participate in the team conference process.
2. Document the interdisciplinary discussion of issues discussed in the criteria as opposed to reports by single disciplines
3. Ensure a team conference occurs for all patients regardless of their length of stay, unless an unexpected discharge from the unit occurs.

Realistic Goals and Significant Practical Improvement – This component of care is significantly impacted by the functional status of the patient at admission and hence the necessity for the admission into an inpatient rehabilitation level of care. If a patient is admitted at a relatively high functional status, then the issue of whether the patient can make significant practical improvement may be questioned. This discussion and determination of the patient's need and ability to make improvements as a result of participation in the inpatient rehabilitation program should be part of the preadmission screening process.

On occasion, documentation of a patient's stay only reflects progress at discharge, when the patient may be making gains, small as they may be, on a daily basis.

A significant percentage of patients admitted to an inpatient rehabilitation program (85% or more) are discharged home; the majority of whom go home with assistance. Therefore, from a medical necessity perspective, it is not necessary to keep the patient in the program until they have reached maximum independence.

SUGGESTIONS:

1. Reflect the amount of progress that a patient is planned to make, within the estimated length of stay within the documentation of the preadmission screening process.
2. Establish goals for the patient that reflect the appropriate level of functioning to be discharged, perhaps to another level of care, e.g., outpatient or home health.
3. Ensure the treatment team is reflecting progress as a result of treatment towards identified goals on a daily basis. For example, consider the plan for a patient being discharged home. In order to be able to meet this discharge plan, it will be necessary for the patient to be able to perform a transfer relatively independently in the evening after the individuals providing assistance during the day have left and before their family members arrive home. A transfer goal may be established by the team with critical documentation coming from nursing who would document the patient's ongoing progress toward improvement their functional status in the evening.

In summary, the majority of denials for improper payments to inpatient rehabilitation providers in the RAC demonstration project were the result of a lack of documentation of medical necessity. The criterion referenced in order to demonstrate medical necessity are not new, but the RACs have significantly and quickly increased the scrutiny placed on inpatient rehabilitation providers to demonstrate meeting these criterion. In the absence of any specific reason being identified by the RAC, it is in a provider's best interest to take the strictest interpretation of the criteria governing inpatient rehabilitation and strive to consistently maintain documentation that clearly and consistently supports all of the criteria. In other words, the medical record must 'tell the story' that the admission to an inpatient rehabilitation program, as opposed to any other level of care, is required for the patient to meet their medical and rehabilitation needs. If an improper payment due to the lack of medical necessity is identified, this patient will also be disallowed from the calculation of the 75% Rule. Therefore, in order to protect both the provider status of the program, and its financial viability, it is critical to be prepared for a RAC review. Providers must perform internal audits to identify any issues that may be problematic in demonstrating the medical necessity of the admission. Corrective actions can then be developed and implemented to resolve any issues prior to a RAC review.

Outpatient Rehabilitation

Impact of RAC Review and Discussion

While the most significant impact on inpatient rehabilitation from the RAC demonstration project occurred with providers in California, the states in which the RAC demonstration project had the most significant impact on outpatient rehabilitation were Florida and New York.

The statistics from the RAC demonstration project include outpatient therapy services in the category of "outpatient hospital". While the figures below reflect the impact of the RACs in "outpatient hospital", it is important to keep in mind that the impact on therapy services was only a small percentage of these figures.

Overpayments by Provider Type *(1)*	***Impact (in millions)***
Inpatient Rehabilitation Facility	$59.7
Outpatient Hospital	$44.0
Physician	$19.9
Skilled Nursing Facility	$16.3
Ambulance/Lab/Other	$5.4
Durable Medical Equipment	$6.3

(1) Cumulative through 3/27/08, NOT net of impact of appeals

Outpatient Hospital – Speech-Language Pathology Services		***% of Total for Outpatient Hospital***
Amount Collected (1)	$3.2M	36.67%
Number of Claims with Overpayments (1)	24,991	55.76%

(1) Less cases overturned on appeal
Source: The Medical Recovery Audit Contract Program: An Evaluation of the 3-Year Demonstration

The errors identified for outpatient therapy services were noted to be due to lack of demonstration of medical necessity for the services and were only identified for speech language-pathology. However, the majority of outpatient therapy providers will agree that the methodology and documentation that is necessary to demonstrate medical necessity for speech language pathology therapy services is similar to that for physical and occupational therapy as well. There is one exception: Most services provided by physical and occupational therapy can be billed with HCPCS codes that define the service in 15 minute increments (with the exceptions of evaluations, group, etc.). For speech-language pathology, the treatments are not defined in 15 minute increments for treatment provided (HCPCS codes 92506 – evaluation, and 92507 - treatment). In other words, if 15 minutes of treatment is provided, one unit of service is billed. If 45 minutes of therapy is provided, one unit of service is billed as well. However, for the purposes of being "ready" for the RACs, all information provided here will be applicable for physical and occupational therapy and speech-language pathology.

There were several facts provided by the RACs about the claims for the identification of improper payment for therapy as follows:

- Billing was for each 15 minutes of therapy with code not defined by 15 minute units.
- Units billed exceed the approved number of sessions per day. Excessive services were not deemed medical necessity.

Therefore, it appears that for therapy provided to beneficiaries on an outpatient basis, the issue was not one of whether the service was defined as "skilled" or not, but whether the billing for the services was accurate.

Discussion and Suggestions to Decrease the Risk of a RAC Review

There are multiple issues in place that impact the accurate billing of services on an outpatient therapy basis. One critical issue is the establishment of a charge master with treatment descriptors that will facilitate accurate charging by therapy staff, and correct download into the accurate HCPCS code for billing purposes. For example, for most outpatient patients who have been referred for speech-language pathology, a total treatment time of 15 minutes would be unlikely. For discussion purposes, consider the patient who attends outpatient speech-language pathology services for 45 minutes. The speech-language pathologist refers to the following charge master to charge for services as follows:

Treatment	***Internal Charge Master Descriptor***	***HCPCS Code***
Speech Language Pathology Evaluation	SL – 1	92506
Speech Language Treatment	SL – 2	92507

With this charge master, the therapist may be tempted to charge for 3 units of service, knowing that the other therapists charge by 15-minute unit service, which would result in billing multiple units of service with a HCPCS code that is an "untimed" code regardless of the amount of time of service provided.

However, consider the use of the following charge master to charge for services:

Treatment	***Internal Charge Master Descriptor***	***HCPCS Code***
Speech Language Pathology Evaluation – 15 minutes	SL – 1	92506
Speech language Pathology Evaluation – 30 minutes	SL – 2	92506
Speech Language Pathology Evaluation – 45 minutes	SL – 3	92506
Speech Language Treatment – 15 minutes	SL – T – 1	92507
Speech Language Treatment – 30 minutes	SL – T – 2	92507
Speech Language Treatment – 45 minutes	SL – T – 3	92507

If this charge master was available, the therapist would charge "SL – T – 3" which would describe the 45 minutes of therapy provided. However, the charge would download to the accurate HCPCS code and the risk of charging an inaccurate number of units of service would be significantly decreased. The confusion about how many units of service to bill when the charge master is not clear occurs daily in the outpatient therapy setting.

The Centers for Medicare and Medicaid Services (CMS) has provided clear information about the billing of services and specific limits for HCPCS codes, e.g., the maximum number of PT evaluation units of services that can be billed in one treatment day associated with HCPCS code 97001 (PT Evaluation) is one unit of service. Most therapy clinicians are not aware of or up-to-date with these billing guidelines. However, establishing a charge master that helps them to bill accurately for services can significantly decrease the risk for a provider to bill for multiple units of untimed services.

CMS has also provided direction as to how many minutes of service can be provided in order to generate one 15-minute unit of service. CMS Claims Processing Manual 100-4, Chapter 5 discusses the issue of what has come to be known as the "8-23 rule". This ruling indicates that when a patient receives at least 8 minutes of service, one 15-minute units of service can be billed; when 23 minutes of service are provided, two 15-minute units of service can be billed, etc. It is important for therapy staff to have a clear understanding of how total treatment time is impacted by the "8-23 rule". For example, a patient receives a 30 minute physical therapy treatment including the following: 8 minutes of therapeutic exercise, 8 minutes of gait training and 8 minutes of neuromuscular retraining. Using the 8-23 rule, the therapist may bill one unit of gait training, one unit of therapeutic exercise and one unit of neuromuscular retraining, per the treatment provided. However, since each one of these HCPCS codes reflects a 15-minute unit of service, this patient may be billed for 45 minutes of service when only 24 minutes of service was provided. This type of billing would put the organization at risk during a RAC review. It is also important to note the descriptor of the HCPCS code reflects treatment that is provided for 15 minutes in length, and services that consistently last only 8 minutes in length or similar would put the organization at risk.

The last critical issue of which to be aware is the potential for unintentional conflicting goals between clinical staff and established productivity or billing targets. There are unique situations which occur in outpatient therapy due to the population served. In outpatient therapy, there are significantly more cancellation of services or "no shows" than in an inpatient setting. Additionally, patients may show up at a time that is not the time at which they were scheduled, while in an inpatient setting, the therapy staff have more control over the scheduling and provision of treatment. , occasionally there are no staff available for covering an unexpected absence of therapy staff, so patients are "spread" among the therapists in attendance for treatment purposes.

Often a high productivity expectation is established for outpatient therapy staff perhaps when a focus has not been provided to creating the most efficient system in which they

can provide care. In addition to the unique situations in outpatient therapy discussed above, often the documentation system is laborious, requiring a significant portion of the therapists' time to complete.

With these conditions in mind, consider the outpatient therapy situation in which an occupational therapist had called in sick, with no additional staff to cover the treatment of patients scheduled, and one therapist is left to cover the number of patients normally seen by two therapists for that one day. The therapist, in many cases, will start one patient out and continue with another patient, with overlapping treatments. In this way, the therapist successfully sees all patients scheduled for both themselves and the absent therapist. When it comes to billing, the therapist may bill all patients for all individual, one-on-one, therapy treatments. However, CMS has provided very clear direction for group vs. individual therapy: individual treatment is provided when a patient receives service by a licensed therapy staff member for a specified period of time. If the licensed therapy staff member is treating more than one patient for the same period of time, the services should be billed using a group therapy charge (untimed unit).

When therapy productivity expectations are high without considering the barriers of staff to meet these expectations, the organization may be at risk of billed services not accurately reflecting treatments provided. For example, similar to the 8-23 rule example above, consider the case of a documentation system requiring therapy staff to spend 5 minutes of each 15-minute treatment session in documentation, and a therapist is scheduled with patients every 30 minutes (no cancellations) for 7.5 hours of the 8 hour work day. There is a very high probability that the staff member will make every attempt possible to treat as many patients as possible, bill for those services and complete the required documentation all within the 8 hour work day, putting the organization at risk for billing for and receiving improper payments.

SUGGESTIONS:

1. Conduct ongoing audits of representative samples of outpatient therapy bills with associated medical records, to include, but not be limited to, the following:
   a. Service(s) are billed for the day(s) services are provided;
   b. Accurate billing of number of units of service billed vs. documented treatment times;
   c. Billing for outpatient therapy services use modifiers as appropriate;
   d. Billing for outpatient therapy services take specific limitations into consideration as directed by CMS; and
   e. Therapy staff receive ongoing training and education as to changes in therapy billing directives from CMS.
2. As discussed above, create provider charge masters that facilitate accurate billing of services.
3. Conduct an assessment of outpatient therapy scheduling, treatment and documentation, and provision of services to determine any risk for inaccurate billing practices.
4. Conduct ongoing audits of representative samples of outpatient therapy bills with associated medical records, to include, but not be limited to, the following:

a. Service(s) are billed for the day(s) services are provided;
b. Accurate billing of number of units of service billed vs. documented treatment times;
c. Billing for outpatient therapy services use modifiers as appropriate;
d. Billing for outpatient therapy services take specific limitations into consideration as directed by CMS; and
e. Therapy staff receive ongoing training and education as to changes in therapy billing directives from CMS.

5. As discussed above, create provider charge masters that facilitate accurate billing of services.
6. Conduct an assessment of outpatient therapy scheduling, treatment and documentation, and provision of services to determine any risk for inaccurate billing practices.

Medical Necessity

While there is no record of the RAC demonstration project yielding identification of improper payments due to lack of demonstration of medical necessity (e.g., services were not necessary), it seems logical that the outpatient setting may experience the same scrutiny as that of the inpatient setting and consider the medical necessity of provision of outpatient services. When considering the medical necessity of the provision of outpatient therapy services, it is important to keep in mind several important factors.

As for inpatient rehabilitation services, CMS has discussed many conditions for which skilled therapy services are not considered to be necessary, e.g., decreased strength and endurance. If a patient can walk for 10' (with appropriate gait sequencing, balance, etc.) and the treatment goal is for the patient to walk 100', the service may be deemed medically unnecessary. It is thought that in time, the patient will continue to gain strength and be able to walk farther without the intervention of skilled therapy service. Therefore, documentation has to very clearly document the necessity of the intervention of a licensed therapy staff member when patients present with similar conditions.

Many times, patients who receive therapy on an outpatient basis may receive treatment for a lengthy period of time. It is important to continue to provide a plan of care/treatment goals that are active, for which treatment is continuing to strive for achievement. Many reviews of medical records will reveal treatment goals that have been achieved with no active treatment plan, or an extensive period of time that the patient has not made any progress (has reached a "plateau"). Therapy staff has to continually discuss the progress made by the patient, need for continuing services, and ongoing and current treatment plan. This information has to be confirmed by the referring physician, so that the prescription for services, treatment plan, etc. remain current.

In summary, the supporting systems for and expectations of outpatient therapy staff have to be aligned and focused on facilitating billing that accurately reflects the therapy services that have been provided and have been determined to be medical necessary.

Therapy staffs can focus on ensuring documentation reflects medical necessity. But, it is only through sharing of knowledge between billing/finance departments and treatment staff, addressing any potential barriers, and performing ongoing auditing of the treatment vs. bills that the risk from a RAC review or a review on a more local basis may be decreased.

Skilled Nursing Facilities

Impact of RAC Review and Discussion

The final level of post acute care that was impacted by the RAC demonstration project was the skilled nursing facilities (SNFs). As all post acute providers are aware, patients in this level of care are admitted for an identified need for skilled nursing and/or skilled therapy but do not require the intensity of rehabilitation program that is provided in an inpatient rehabilitation program. The treatment team in a SNF may be similar to that in an inpatient rehabilitation program and include a combination of nursing (although not specifically rehab nursing) and therapy. However, in a SNF setting the focus is not on a 24/7 therapeutic environment or an interdisciplinary treatment team as in an inpatient rehabilitation setting.

Of the approximately $1.03 billion in improper payments identified in the demonstration project by the RACs, $16.3 million or 2% of the total was identified from skilled nursing facilities. Similar to inpatient rehabilitation providers, all of the errors for SNFs were identified by the RAC in California. But, unlike inpatient or outpatient rehabilitation providers, there were multiple reasons noted for the improper payments, as follows:

Overpayments Collected by Error and Provider Type *(1)*

Error Type	*Percent of Total*
Medically Unnecessary	0.26
Incorrectly Coded	0.62
No/Insufficient Documentation	0.48
Other	0.41
Total	**1.77**

(2) Cumulative through 3/27/08;

Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-year Demonstration, June, 2008

While there were several error types noted, it was also noted that the services with the most overpayment collections were physical and occupational therapy and speech language pathology ($1.9 M and $1.5 M respectively).

Incorrect Coding and Medical Necessity

In the skilled nursing setting, there are two types of coding to be considered: diagnostic coding and the coding necessary for reimbursement assignment. However, the discussion about incorrect coding is so closely aligned and connected with the discussion of medical necessity, this section discusses both.

The causes for errors in diagnostic coding in a skilled nursing setting often mirror that which may occur in acute care: a diagnostic code is assigned without having supporting documentation for the treatment of that diagnosis in the medical record.

Since the skilled nursing facility transitioned from a cost-based reimbursement system to a prospective payment system, reimbursement has been paid based on the assignment of a Resource Utilization Group (RUG). There are two major categories of payment in the RUG reimbursement system: rehabilitation RUGS and medical RUGs. For the rehabilitation RUGS, reimbursement is assigned based on the number of minutes of therapy provided during the assessment period. If the RUG category assigned is not supported in documentation, then inaccurate payment may be received. For example, if the RUG reimbursement is based on 720 minutes of therapy provided (Rehabilitation Ultra High Category), and the documentation does not reflect that number of minutes of therapy provided, then there has been an error in coding the reimbursement category.

Also, for therapy treatment to be provided, it has to be reasonable and appropriate treatment for the diagnosis identified. For example, it would not be reasonable for treatment to be provided in hopes of a patient/resident exceeding the level of functioning prior to admission. If a patient/resident required assistance to perform activities of daily living prior to admission to a skilled nursing facility following an infectious medical condition, the goal to return the patient/resident to an independent level of functioning may not be considered reasonable and appropriate.

To exemplify two of the potential situations above, consider the admission of a patient/resident to a skilled nursing setting for the treatment of polyneuropathy. Admission orders are written for therapy services, and the patient/resident receives both nursing and therapy care. However, in review of the medical record, documentation supports that the patient/resident has a lack of strength and endurance, but there is a weakness in demonstration for the diagnosis of polyneuropathy (e.g., therapists do not note any weakness or lack of sensation in any extremities, and endurance is not noted to be any different than that of a patient/resident with the age of the admitting patient). In this case, the treatment for a diagnosis that is not demonstrated would not be medically necessary and the coding for the diagnosis of polyneuropathy would not be accurate.

A situation that may impact accurate coding is the logical, clinical progression of the patient/resident during the stay. For example, consider the situation when a significant number of therapy minutes are provided during the initial assessment period, establishing a reimbursement rate. If a patient suddenly requires less therapy than was identified as being necessary in the initial assessment period, it may raise a question as to the potential of inaccurate cording.

And finally, a discussion of medical necessity for a SNF could not be complete without mentioning the patients/residents who may have been referred and admitted to a SNF level of care if the physician feels “they just need a few more days of care and aren’t quite ready to go home”. Quite often, this patient would be deemed appropriate to go

home and perhaps receive therapy on a home health or outpatient or nursing on a home health basis.

SUGGESTIONS:

1. If the estimated length of stay for the admission is short, question the medical necessity of the admission and see if the patient could be discharged home with services.
2. Ensure that the assessments of the therapy and nursing staff support the diagnoses for which the patient/resident is admitted to the skilled nursing facility. It is helpful to the staff to have knowledge of those diagnoses prior to the initiation of the assessment process and be able to discuss the conditions requiring treatment following the assessment process, perhaps in the care planning meeting.
3. Audit the medical records of the patients/residents to ensure the number of minutes documented as having been provided match the number of minutes that result in the assignment of the RUG category.
7. Develop and implement a system to manage therapy minutes within the assessment period that reflect the needs of the patient/resident during their assessment period and throughout their stay.

No/insufficient Documentation

Every issue that has been discuss thus far has addressed the importance of the content of the medical record documenting the care needed by and provided to the patient, and that care being necessary for the identified diagnosis. As previously addressed, when the medical record process moves to an electronic format, there is a tendency to lose some of the information that is critical to supporting medical necessity or the diagnosis.

In summary, most of the topics discussed herein are applicable to the SNF setting and will be necessary to be reduce the risk of a review by the RAC.

SUGGESTIONS:

1. Conduct an internal audit of the content of the medical records of patients/residents admitted to the SNF to ensure that the patient has a stated and justified need for admission to the unit skilled nursing and/or skilled therapy services).
2. Ensure documentation supports treatment of the diagnosis(es) for which the patient was admitted to the SNF.
3. Track ongoing therapy to ensure that progress is occurring and that there was not a sudden decrease in the amount of therapy provided after the assessment period was over.
4. Track therapy minutes in the medical record to correlate with the number that are downloaded into the minimum Data Set.
5. Audit the medical records of the patients/residents to ensure the number of minutes documented as having been provided match the number of minutes that result in the assignment of the RUG category.

Long Term Acute Care Hospitals (LTACHs)

There is no evidence from the RAC Demonstration Project that there was any impact on LTACHs. However, recently there has been some focus of the RAC in South Carolina on the LTACH level of care. Similar to the focus in other post acute levels of care, the RAC considered the medical necessity of admissions to the LTACH. In order to help LTACH providers prepare for the RACs, and host hospitals be prepared for any potential impact from these efforts, this section of the Post-Acute chapter of the RAC Readiness Manual will briefly review factors that would be critical to supporting the medical necessity of an admission to an LTACH..

General Background

Long Term Acute Care Hospitals (LTACHs) are a separate Medicare provider type created in the early 1980's as the Inpatient Prospective Payment System (IPPS) was being launched. They were a collection of acute care hospitals that did not fit the IPPS payment scheme, primarily due lengths of stay which exceeded short term acute care. Initially, LTACHS served a wide range of patients from those with tuberculosis to those requiring intensive long term physical rehabilitation. As practices in the care of more acutely ill patients have advanced, LTACHs have expanded their patient mix to include those with respiratory disease, complex wound care or patients with multiple co-morbidities.

For two decades, LTACHs were exempted from being paid on a prospective basis and were paid on reasonable costs. In Federal FY 2003, Medicare began paying LTACHs under a prospective, DRG based system, delineated in separate LTCH-PPS rules. Since the inception of the LTCH-PPS, the Centers for Medicare and Medicaid Services (CMS) has instituted fairly dramatic changes in payment policy designed to substitute for patient and facility level criteria (which have been lacking). These policies have included dramatic reductions in payment for patients who stay less that the Geometric Mean Length of Stay (GMLOS) and limitations on the percentage of referrals from a given hospital (the so-called "25% Rule").

Some of these recent payment rules have been temporarily suspended in conjunction with a moratorium on new LTACH bed expansion. This moratorium is scheduled to sunset (with reimposition of these payment rules) at the end of calendar 2010. No doubt, the industry will be seeking additional relief to avoid this from occurring.

Georgia

In Georgia, LTACHs are licensed as Specialized Hospitals with service specific Certificate of Need Rules which the Department of Community Health (developed in 2006). There are a small number of freestanding LTACHs in Georgia. Most LTACHs, however, have a "Hospital Within A Hospital (HWH) model. In its most basic form, a HWH is a separate entity that leases space, licensed beds and services from a host hospital (also referred to as a co-located hospital).

Changes in the regulatory oversight of LTACH HWHs are not the responsibility of the host hospital. However, for short term acute care hospitals, the LTACH provides a placement option for their potential long term care or complex patients. As the scrutiny of the LTACH increases based on the definition of "appropriate" admissions and the medical necessity of an an admission to an LTACH, it is critical that host hospitals are aware of changes that may negatively impact their tenant including the future efforts of the RAC program..

Quality Improvement Organization (QIO) Oversight

Quality Improvement Organizations have provided many of the same oversight functions for LTACHs as they have for General Acute Care Hospitals. The one striking difference is that, due to a lack of programmatic funding, there has been a very limited review of retrospective claims review. In the recent past, this has resulted to a review of only 1,400 claims per year nationwide (an average of only 3-4 per hospital per year). The focus of this review has only been for appropriate admission practices; continued stay practices have not generally been reviewed. In the FY 2007 LTACH update rule, CMS reported that 7.9% of LTACH admissions, based on this small sample size, were unnecessary. Based on this limited review, clearly, there has been little oversight of the Utilization Management function of LTACHs.

Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)

Until recently, there have been few criteria which guide the operations of the LTACHs. Patients must require an acute level of care and Medicare beneficiaries must average a 25 day length of stay (as calculated on a cost reporting year basis). The MMSEA of 2007 established significant changes in both the Conditions of Participation (COP) for LTACHs and the degree and scope of scrutiny with which claims will be reviewed in the future.

Included in the expanded COP are mandatory certification standards including:

- Patient screening prior to admission for appropriateness of LTACH admission.
- Validation that patient meets LTACH criteria within 48 hours of admission.
- Evaluation at regular intervals throughout a patient's stay that they are appropriate for continued care in an LTACH setting.
- Discharge options are assessed when patients no longer meet continued stay criteria.

While not mandating specific admission, continued stay and discharge criteria, CMS clearly expects LTACHs to demonstrate that they have such criteria in place.

In the MMSEA, Congress directed CMS to increase the intensity of medical necessity review from 1,392 cases in FY 2005 to a number which will "guarantee that at least 75% of overpayments received by LTACHs for medically unnecessary admissions and

continued stays will be identified and recovered." In addition, continued stay practices will also be included which represents a new level of oversight.

While the burden imposed by the Recovery Audit Contractors (RACs) is as significant to LTACHs as it is to other post acute providers, LTACHs will quickly transition from a low level of claims review scrutiny to intense review by RACs, Fiscal Intermediaries and other Medicare Administrative Contractors (MACs).

Office of the Inspector General (OIG)

The OIG provides some insight into areas that RACs may focus. In their 2008 Work Plan, the OIG continued its prior focus on interrupted stays (when a patient is discharged from an LTACH and then returns within specified time periods). Interrupted stays occur when patients require services that are not available in that particular LTACH.

However, three initiatives are new:

1. Short Stay Outliers – Patients whose length of stay (LOS) is less than 5/6 of the Geometric Mean Length of Stay (GMLOS) are defined by CMS as short stay outliers (SSO). Payment to LTACHs is reduced below a full LTC-DRG payment when a patient is in this category.

2. LTACH Readmissions from a Co-Located Hospital – Beyond the interrupted stay concerns referenced above, there are special payment provisions (reductions) when an HWH transfers back to, and then readmits from, its host hospital more than 5% of its Medicare inpatients discharged during a cost reporting year. While not a new rule, the OIG is concerned that these reductions may not be occurring as prescribed.

3. Special Payment Provisions for Patients Admitted from Co-Located Hospitals – The OIG wants to determine if payment to HWH and Satellite LTACHs is appropriately reduced when they admit patients from their host hospital in excess of the threshold under the so-called 25% Rule.

On March 21, 2008, a report to CMS from the Office of the Inspector General (OIG) expressed additional concern over SSO patients and the apparent manipulation of length of stay by LTACHs for payment purposes.

Patients who are discharged ten or more days prior to reaching the SSO threshold (5/6 of the GMLOS for a given LTC-DRG) are referred to as "very short stay outlier cases" (VSSO). OIG suggests that these patients should have remained in the short term acute care hospital and constitute inappropriate discharges from the short term acute care hospital. This type of case represents more than one third of total LTACH SSO cases. Short term acute care hospitals have very little visibility into the length of stay of patients they refer to LTACHs. A payment rule specifically designed to penalize LTACHs for

VSSO admissions has been temporarily suspended under the moratorium referenced above.

The OIG noted that during the first three years of the implementation of the LTC-DRG payment system, there was a dramatic increase in the incidence of patients who were discharged from LTACHs within two days after the qualifying for full LTC-DRG payment. The implication is that LTACHs may unnecessarily hold patients for payment purposes or perhaps to meet the 25-day ALOS requirement. It seems logical, then, that one area which may be reviewed by the RAC may be patients who meet these criteria.

Importance of an Active Utilization Management Program

The necessity of having a well developed and engaged Utilization Management (UM) Program cannot be overstated. Key to this is demonstration of the new COPs which address having and using criteria for admission screening, continued stay and discharge. While there is debate within the industry concerning its validity, the prevalence of the use of InterQual ® Level of Care Criteria (McKesson Corporation) by QIOs and many LTACHs should be noted.

Recent RAC experience by South Carolina LTACHs during the demonstration project suggests the following actions would be considered prudent RAC preparedness activities:

- Review the PEPPER Report provided by the Georgia Medical Care Foundation to identify where you may be exceeded the norm in targeted LTC-DRGs.

- Ensure that the admission H&P clearly indicates the need for an acute level of care. Many RAC denials were for admissions of patients which may have been able to be cared for in a subacute setting. While documenting a lack of adequate subacute services in the area may explain a delay in discharge from a short term acute care hospital, it is not sufficient to justify an LTACH admission.

- Review the adequacy of your hospital's coding function and the quality of physician documentation. The extremely limited level of claims review in the past may give a false sense of security. Consider periodic reviews of coding accuracy by a qualified outside source.

Summary of RAC Readiness for Post Acute Care

The RACs in the demonstration states identified errors in payment in three levels of post acute care: inpatient rehabilitation (California), outpatient therapy (Florida and New York) and skilled nursing facilities (California). The percentage of errors in these three settings was not a significant percentage of the total overpayments collected by providers (approximately 8 – 10% of the total). When considering the total amount of overpayments, the amount identified in the post acute providers does not seem that significant (just over $76 M). Subsequent to the Demonstration Project, RACs began to look at the medical necessity of admissions to the LTACHs.

When the post acute provider is part of a larger acute care entity, their impact may only be a small part of the overall operational pie. But, for post acute providers in the demonstration project, separate and apart from a larger entity, the dollar amount was significant. The Centers for Medicare and Medicaid Services (CMS) reported that only 14% of the overall RAC determinations had been appealed and only 4.6 of those had been overturned in the appeal process.[5] However, individual post acute providers have reported that the impact of the RAC was significant for them and the amount of time spent in the appeal process was excessive. One administrator of an inpatient rehabilitation provider indicated they were spending 100%+ of their time "handling" the appeals. The providers also report that they had a high success rate of appealing the denials, but most of that success was the result of taking the appeal process to the level of the Administrative Law Judge (ALJ) review. Due to the time frames of the appeal process discussed earlier in this Manual, one can see how the time spent in the appeal process could result in significant cash flow issues. And many providers reported a change in operations for fear of RAC review, regardless of their surety that the patients were appropriate for admissions and subsequent billing.

For all of the improper payments, the key component in the review was the medical record. In order to reduce the risks of a potential RAC review, it is critical that all post acute providers are proactive in identifying and determining what a review would reveal, prior to the actual review occurring. In other words, ongoing audits and reviews of the medical record will identify weaknesses in the reliability, validity, accuracy and completeness of the medical record and give the provider a chance to identify the issues, develop a corrective action, and implement all changes as quickly as possible. For post acute providers, it is important that these internal audits and reviews be conducted by individuals with the expertise to identify potential issues.

It is also important to remember that once the record is open for review, the whole content is subject to scrutiny. For example, if an outpatient therapy record is requested for review of the support for the treating diagnosis, and it is determined that individual therapy is charged when group therapy was provided, an improper payment is identified.

[5] The Medicare Recovery Audit Contractor (RAC) program: An Evaluation of the 3-Year Demonstration, June, 2008.

If an inpatient rehabilitation record is requested for review of the support for the medical necessity of the admission of a joint replacement patient and medical necessity is supported but it is determined that inaccurate payment was received due to inaccurate scoring on the Patient Assessment Instrument, an improper payment is identified. And if a skilled nursing facility record is requested for review of the medical necessity of therapy services, and it is determined that the RUG was assigned with an inaccurate count of therapy minutes, an improper payment is identified.

In summary, none of the issues that impacted the post acute providers in the demonstration project are "new" issues, with the exception of the LTACHs which have new regulations and COPs within which to ooperate. However, for all levels, what is new, is the scrutiny placed upon post acute providers as a result of the RAC reviews. Questions may be raised as to why correction of these issues has not occurred in the past. The answer may be that until recently, there was a lack of scrutiny of these issues – no one was reviewing these issues, and perhaps oversight became relaxed. Whatever the cause, it is time for post acute providers to increase their internal awareness of their own risks, correct them, and proactively be ready for a RAC review.

CHAPTER 8:

EDUCATION & TRAINING

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PowerPoint Presentations

1. Executive/Board Level Training

(30 slides)

Medicare Recovery Audit Contractors (RACs)

Preparing for RAC Audits

Presentation Outline

- I. Background
  - A. What are the RACs?
  - B. When are the RACs coming to Georgia?
  - C. RAC Focus Areas
- II. Case Studies
- III. How to Prepare for RACs
- IV. GHA Initiatives to Assist Member Hospitals with RACs

What are RACs?

- Medicare Modernization Act of 2003 created a 3-year demonstration project in NY, FL, CA
- Recover Medicare overpayments and identify underpayments—payment mistakes
- RACs are paid on a contingency fee basis
- During FY 2007, RACs identified and corrected $371 Million dollars of Medicare improper payments in the demonstration states
- Over 96% were overpayments

Why Congress Believes RACs are Necessary…

- The Improper Medicare FFS Payments Report for November 2007 estimates that 3.9% of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules.
- This equates to $10.8 billion in Medicare FFS overpayments and underpayments annually.

Overpayments by Error Type in Demonstration Project

- 42% Incorrectly coded
- 32% Medically unnecessary service or setting
- 9% No/Insufficient Documentation
- 17% Other

Source: CMS RAC Status Document FY 2007, February 2008

Average Overpayment Amounts FY 2007

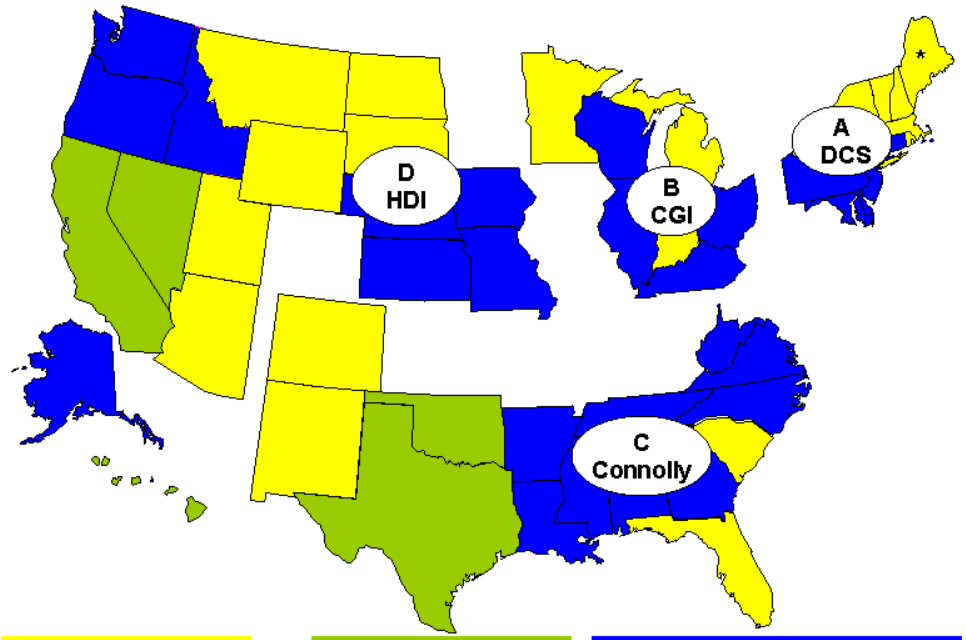
	Per Claim	Per Provider
Inpatient Hospital/SNF	$10,618	$549,447
Outpatient Hospital	$273	$38,136
Physician	$160	$834
DME	$85	$1,511
Total	$11,136	$589,928

Source: CMS RAC Status Document FY 2007, February 2008

Permanent RAC Program

- CMS will contract with a permanent regional RAC in 4 regions (the RAC for Georgia is Connolly Consulting)
- RACS can review claims for:
  - Inpatient hospital
  - Outpatient hospital
  - Skilled nursing facilities
  - Physician, ambulance, and lab services
  - Durable medical equipment

RAC Phase In Schedule



Permanent RAC Program

- RACs cannot look for any improper payments on claims paid before October 1, 2007
- RACs can review claims during the current fiscal year
- Each RAC must use certified coders
- RACs must pay back contingency fee if their decision is reversed on any level appeal

Types of RAC Reviews

- Automated Review
  - Proprietary software algorithms used to identify clear errors that resulted in improper payments
- Complex Review
  - Medical records requested to further review the claim

RACs must use Medicare coverage, coding or billing policies in **effect at the time when the claim was adjudicated**

RAC Focus Areas in Demonstration States

- Excisional Debridement
- Back Pain
- Outpatient vs. Inpatient Surgeries
- Transfer Patients
- Inpatient Rehab, especially knee and hip replacements
- Joint replacement patients and patients in inpatient rehabilitation facilities that should have been treated in a lower intensity setting such as a SNF
- Wrong diagnosis or principal procedure codes

Outpatient Hospital Areas of RAC Focus

- Colonoscopy
- Speech Language Pathology Services
- Infusion Services
- Neulasta (boosts white blood cell counts to reduce chance of infection in patients undergoing chemotherapy)

Short Stay Claims

- Validate whether the admissions met Medicare's medical necessity criteria
- One-day stays by chest pain patients were targeted by RACs in demonstration states
- Many three-day stays were denied because they were inappropriately extended in order to qualify for Medicare Part A coverage of post-acute skilled nursing care

Some Case Examples from the Demonstration States

- (Note: These slides are optional depending on how the CEO wants to present this information to the board members)

Excisional Debridements

- Hospital coder assigned a procedure code of 86.22 (excisional debridement of wound, infection, or burn)
- In the medical record, the physician writes "debridement was performed"

Excisional Debridements

- Coding Clinic 1991 Q3 states "unless the attending physician documents in the medical record that an excisional debridement was performed (definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of the skin that does not meet the criteria noted above or is described in the medical record as debridement and no other information is available should be coded as 82.26 (ligation of dermal appendage)."

Excisional Debridements

- The RAC determines that the claim was incorrectly coded and issues repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the payment amount for the correctly coded procedure.

Wrong Principal Diagnosis

- Principal diagnosis on claim did not match the principal diagnosis in the medical record
- Example: Respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis

Wrong Principal Diagnosis

- The RAC issued overpayment request letter for the difference between the amount for the incorrectly coded services and the amount for the correctly coded services
- Most common DRGs with this problem:
  - DRG 475 Respiratory System Diagnoses
  - DRG 468 Extensive OR Procedure Unrelated to Principal Diagnosis

Wrong Diagnosis Code

- Hospital reported a principal diagnosis of 03.89 (septicemia)
- Medical record shows diagnosis of urosepsis, not septicemia or sepsis; Blood cultures were negative
- Did not meet the coding guidelines for "septicemia". Urinary tract infection causes the claim to group to a lower payment DRG

Wrong Diagnosis Code

- RAC issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure

Colonoscopy

- The hospital billed for multiple colonoscopies for the same beneficiary the same day
- Beneficiaries never need more than one colonoscopy per day. The excessive services are not medically necessary.
- The RAC issued overpayment request letters for the difference between the billed number of services and 1.

Outpatient Hospital Speech Therapy

- The outpatient hospital billed for each 15 minutes of speech therapy
- The code definition specifies that the code is per session, not per 15 minutes
- The units billed exceeded the approved number of sessions per day. The excessive services billed are medically unnecessary
- RAC issued overpayment request letters

Coping with the RACs

- Comply with RAC medical record requests. If you don't submit them on time, the RAC automatically classifies the claim as an overpayment and makes a recovery.
- Develop an internal tracking system for medical records requested for review by the RAC

Review Your PEPPER Reports

- Program for Evaluating Payment Patterns Report (PEPPER)
- Formerly Prepared by QIO, then Support QIO- no one knows if they will continue
- Identifies claims patterns that are outliers relative to other hospitals in the state
- "Top 20" list of DRGs that are prone to certain billing areas
- Other problem areas which vary by state

Hospital Next Steps

- Look at potential areas of risk
- Establish single point of contact for RAC
- Establish RAC committee—include key hospital stakeholders (finance, UR, Case Management, compliance, legal, medical records, etc.)
- Review records before sending to RAC
  - Support your claim
- Understand the parameters
  - For Providers
  - For the RAC

Hospital Next Steps

- Plan to participate in the AHA's RACTrac to report your hospitals experience with the RAC
- www.AHARACTrac.org
- Data will provide both the AHA and GHA the data they need to advocate on behalf of the hospitals and to identify trends in reasons for denials
- Implement a system for charging RACs for copying costs of medical records (.12/page)

GHA Next Steps

- Establish RAC Task Force
- Establish relationship with RAC—the RAC for Georgia will be Connolly Consulting
- Facilitate information exchange between CMS, RAC, and hospitals
- Monitor RAC activities with Georgia providers
- Georgia is scheduled to begin RAC Activity August 1, 2009 or later

GHA RAC Task Force

- A multi-disciplinary cross-section of GHA members including CEOs, CFOs, legal counsel, compliance officers, case/utilization managers, medical records, and others
- Task Force will provide guidance and feedback to GHA as we develop strategies and tools to assist members in dealing with RACs

Questions or Comments?

- Feel Free to Contact GHA Staff for assistance
- Robert E. Bolden—rbolden@gha.org, (770) 249-4505
- Liz Schoen, lschoen@gha.org, (770) 249-4564
- www.gha.org

2. Staff Training

(50 slides)

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- IV. GHA Initiatives

What are RACs?

- Medicare Modernization Act of 2003 created a 3-year demonstration project
- Recover Medicare overpayments and identify underpayments—payment mistakes
- RACs are paid on a contingency fee basis
- 3 states selected for the demonstration project based on highest per capita Medicare utilization—NY, FL, and CA

What are RACs?

- The Tax Relief and Health Care Act of 2006 required DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010.
- The RAC program does not detect or correct payments for Medicare Advantage plans (Medicare Part C) or for the Medicare prescription drug benefit (Medicare Part D)

Why Congress Believes RACs are Necessary…

- The Improper Medicare FFS Payments Report for November 2007 estimates that 3.9% of the Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules.
- This equates to $10.8 billion in Medicare FFS overpayments and underpayments annually.

RAC Demonstration

- During FY 2007, RACs identified and corrected $371 Million dollars of Medicare improper payments in the demonstration states
- Over 96% were overpayments
- About 85% of overpayments were from inpatient hospital providers
- About 6% of overpayments were from outpatient hospital providers

How Do RACs Choose Cases for Review?

- Data mining techniques
- RACs used the findings of OIG and GAO reports to help target their review efforts
- Comprehensive Error Rate Testing (CERT) reports
  http://www.cms.hhs.gov/CERT/CR/list.asp
- Experience and knowledge of RAC staff

Overpayments by Error Type in Demonstration Project

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Average Overpayment Amounts FY 2007

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Permanent RAC Program

- RACS can review claims for:
  - Inpatient hospital
  - Outpatient hospital
  - Skilled nursing facilities
  - Physician, ambulance, and lab services
  - Durable medical equipment

Permanent RAC Program

- Look back period is 3 years
- RACs cannot look for any improper payments on claims paid before October 1, 2007
- RACs can review claims during the current fiscal year
- Each RAC must use certified coders

Permanent RAC Program

- Mandatory limits set by CMS on medical record requests
- Mandatory discussion with the RAC Medical Director regarding claim denials if requested by providers
- Frequent problem area reporting is mandatory
- RACs must pay back contingency fee if their decision is reversed on any level appeal

Permanent RAC Program

- Each RAC must have a web-based application that allows providers to customize addresses and contact information or see the status of cases
- External validation process is mandatory and it is a uniform process

Permanent RAC Program

- CMS will announce the permanent RACs for the four regions around July 31, 2008

http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf - Microsoft Internet Explorer

File Edit Go To Favorites Help

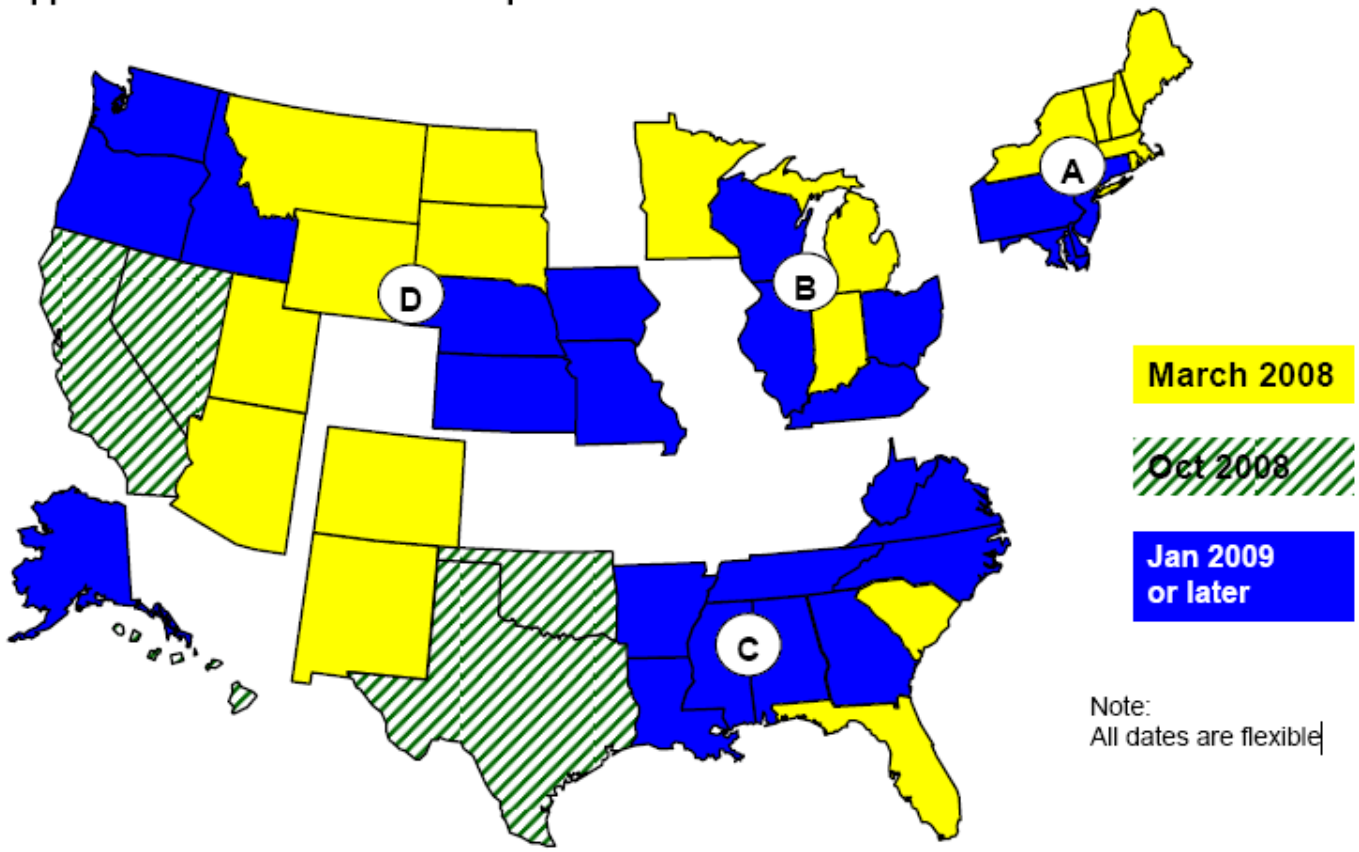
Back Search Favorites

Address http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf Go Links

Save a Copy Search Select 115% Sign

Bookmarks Pages Attachments Comments

Appendix D – Permanent RAC Expansion Schedule



Note:
All dates are flexible

(31 of 31)

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RACs Focus on Hospitals

- In the three demonstration states, 89% of improper payments were from hospitals

RAC Review Process

- RACs use proprietary automated software programs to identify potential payment errors
- Types of payment review
  - Duplicate payments
  - FI errors (i.e. claims paid using an outdated fee schedule)
  - Medical necessity
  - Coding errors
  - No documentation or insufficient documentation to support the claim

Types of RAC Reviews

- Automated Review
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- Complex Review
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RACs must use Medicare coverage, coding or billing policies in **effect at the time when the claim was adjudicated**

Automated Reviews

- Excessive Units Audit—two or more identical surgical procedures for the same beneficiary on the same day at the same hospital
- Use of incorrect discharge status codes
- Medically unbelievable situations (i.e. prostate procedure on a female)

RAC Focus Areas in Demonstration States

- Excisional Debridement
- Back Pain
- Outpatient vs. Inpatient Surgeries
- Transfer Patients
- Inpatient Rehab, especially knee and hip replacements
- Joint replacement patients and patients in inpatient rehabilitation facilities that should have been treated in a lower intensity setting such as a SNF
- Wrong diagnosis or principal procedure codes

DRGs Scrutinized in Demonstration States

- 079 Respiratory infections and inflammations age >17 w CC
- 416 Septicemia age >17
- 468 Extensive OR procedure unrelated to principal diagnosis
- 475 Respiratory System diagnosis with ventilator support
- 477 Non-extensive OR procedure unrelated to principal diagnosis
- 483 Tracheostomy with mechanical vent—96+ hours
- 217 Wound debridement
- 397 Coagulation disorders
- 124 Circulatory disorders except AMI w Card Cath & Complex Diag
- 076 Other respiratory system OR procedures w CC
- 415 OR Procedures
- 082 Respiratory Neoplasms
- 148 Major Bowel

Note: These DRGs are from the version 25 grouper. These are not MS-DRGs.

Outpatient Hospital Areas of RAC Focus

- Colonoscopy
- Speech Language Pathology Services
- Infusion Services
- Neulasta (boosts white blood cell counts to reduce chance of infection in patients undergoing chemotherapy)

Short Stay Claims

- Validate whether the admissions met Medicare's medical necessity criteria
- One-day stays by chest pain patients were targeted by RACs in demonstration states
- Many three-day stays were denied because they were inappropriately extended in order to qualify for Medicare Part A coverage of post-acute skilled nursing care

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Excisional Debridements

- The RAC determines that the claim was incorrectly coded and issues repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the payment amount for the correctly coded procedure.

Inpatient Rehabilitation

- An inpatient rehabilitation facility (IRF) submitted a claim for inpatient therapy following a single knee replacement
- Medical record indicated that although the beneficiary required therapy, the beneficiary's condition did not meet Medicare's medical necessity criteria for IRF care (HCFA Ruling 85-2 and Medicare Benefit Policy Manual Section 110)

Inpatient Rehabilitation

- Entire claim was denied by RAC
- The RAC determines that the service was medically unnecessary for the inpatient setting and issues repayment request letters for the entire claim

Wrong Principal Diagnosis

- Principal diagnosis on claim did not match the principal diagnosis in the medical record
- Example: Respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepis (code 038-038.9) was the principal diagnosis

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Wrong Diagnosis Code

- RAC issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure

Neulasta

- In the past, the billing code for the drug Neulasta (Pegfilgrastim) indicated that providers should bill 1 unit for each milligram of drug delivered
- Several years ago, CMS changed the definition of the billing code to indicate that providers should bill 1 unit for each vial of drug delivered

Neulasta

- The hospital billed for 6 units of Neulasta
- The RAC determined that 5 units of service were medically unnecessary and issued a repayment request letter for the difference between the payment amount for 5 unnecessary vials

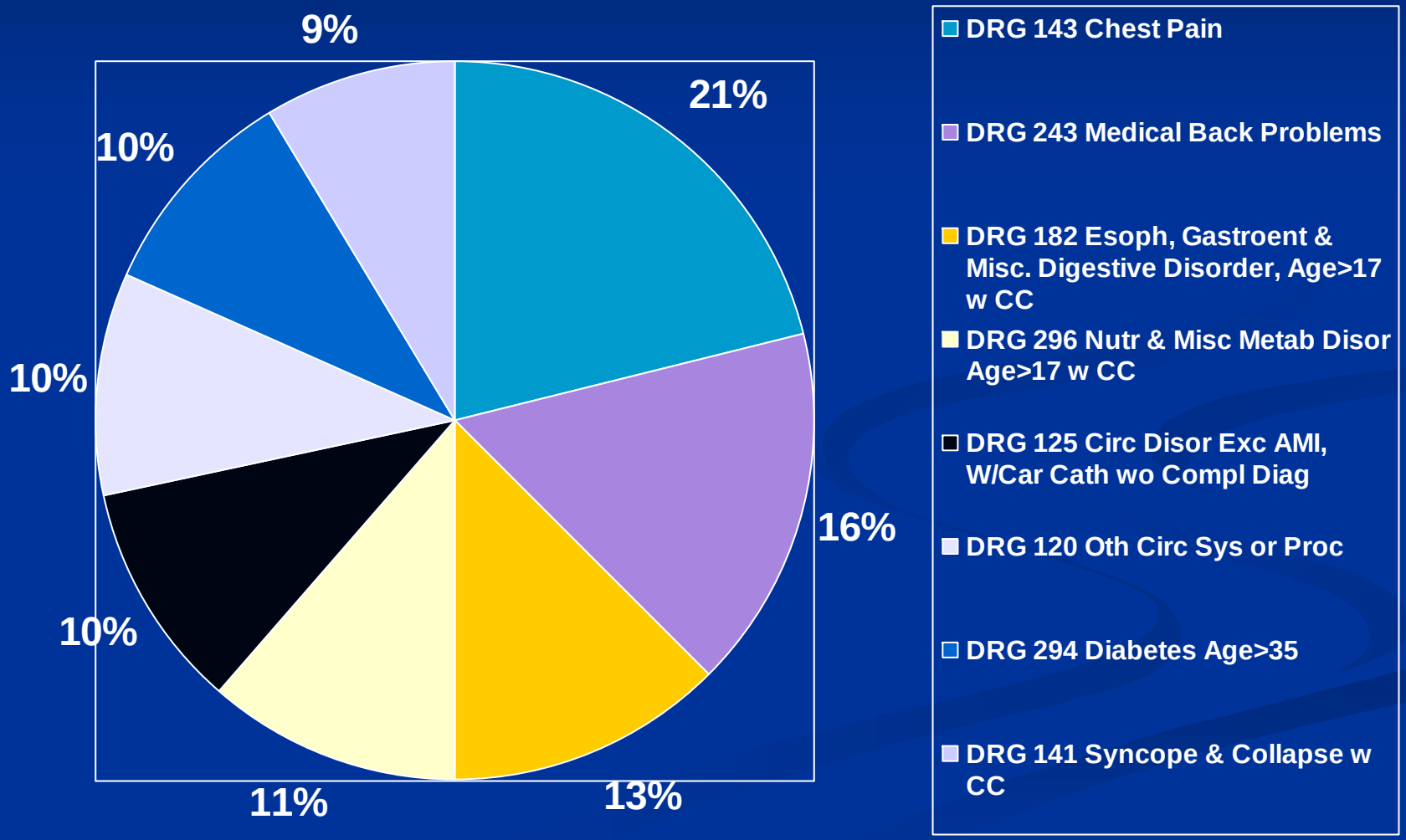
Colonoscopy

- The hospital billed for multiple colonoscopies for the same beneficiary the same day
- Beneficiaries never need more than one colonoscopy per day. The excessive services are not medically necessary.
- The RAC issued overpayment request letters for the difference between the billed number of services and 1.

Outpatient Hospital Speech Therapy

- The outpatient hospital billed for each 15 minutes of speech therapy
- The code definition specifies that the code is per session, not per 15 minutes
- The units billed exceeded the approved number of sessions per day. The excessive services billed are medically unnecessary
- RAC issued overpayment request letters

Most Frequent Medically Unnecessary Errors



Coping with the RACs

- Comply with RAC medical record requests. If you don't submit them on time, the RAC automatically classifies the claim as an overpayment and makes a recovery.
- Develop an internal tracking system for medical records requested for review by the RAC

One-Day Stays

- Develop a system for clarifying unclear admission orders prior to admission
- Implement the "admit to case management protocol"
- Train utilization/case managers on how to determine medical necessity through the use of screening criteria

One-Day Stays

- Involve Case Management/Utilization Review staff early in the process.
- Provide Case Management/Utilization Review staff to perform initial review of medical necessity for admission while the patient is in the emergency department.
- Place UR staff at every point of entry into the hospital (ED, day surgery, centralized admission center, etc.)

One-Day Stays

- Develop condition-specific pre-printed order sheets that include the appropriate patient status.
- Provide Case Management/Utilization Review staffing during weekends and after hours to ensure timely review for medical necessity.

One-Day Stays

- Train hospital staff (nurses, ED staff, unit clerks, day surgery staff and CM/UR staff) on Medicare's requirements for appropriate documentation of medical necessity, the use of observation, requirements for changing patient status and use of Condition Code 44.

One-Day Stays

- Use documentation prompters, stickers on observation charts, and prompters and posters in physician dictation areas to remind physicians of appropriate use of outpatient observation.
- Provide one-on-one education to physicians who consistently write unclear admission orders or consistently have inappropriate one-day stays.

Review Your PEPPER Reports

- Program for Evaluating Payment Patterns Report (PEPPER)
- Prepared by gmcf
- Identifies claims patterns that are outliers relative to other hospitals in the state
- "Top 20" list of DRGs that are prone to certain billing areas
- Other problem areas which vary by state

Hospital Next Steps

- Look at potential areas of risk
- Establish single point of contact for RAC
- Establish RAC committee—include key hospital stakeholders (finance, UR, Case Management, compliance, legal, medical records, etc.)
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- www.AHARACTrac.org
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- Implement a system for charging RACs for copying costs of medical records (.12/page)

GHA Next Steps

- Establish RAC Task Force
- Establish relationship with RAC—once RAC is announced for our region
- Facilitate information exchange between CMS, RAC, and hospitals
- Monitor RAC activities with Georgia providers

GHA RAC Task Force

- A multi-disciplinary cross-section of GHA members including CEOs, CFOs, legal counsel, compliance officers, case/utilization managers, medical records, and others
- Task Force will provide guidance and feedback to GHA as we develop strategies and tools to assist members in dealing with RACs

RAC Resources

- http://www.cms.hhs.gov/RAC/
- http://www.cms.hhs.gov/CERT/CR/list.asp

APPENDIX A

TABLE OF CONTENTS

A. CMS Documents

Medicare Recovery Audit Contractors (RACs):

An Introduction to the RAC Program

Outline

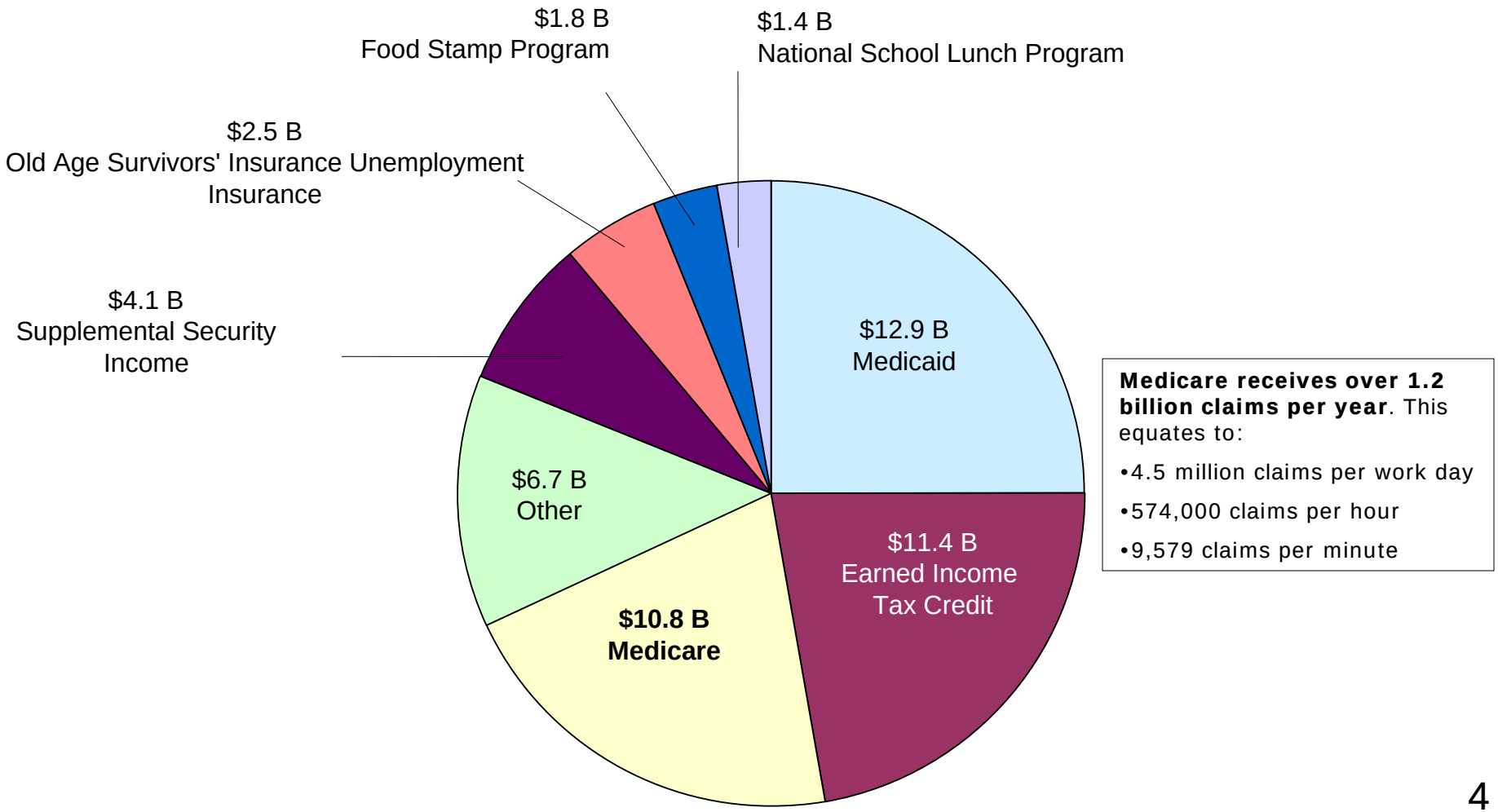
- Background on Improper Payments
- RAC Procedures
- Demonstration Findings
- Expansion

Background: IPIA

- Improper Payment Information Act requires federal agencies to measure and reduce improper payment rates
- "Improper payments" include
  - overpayments
  - underpayments

Background: The Big 8

Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.



Medicare receives over 1.2 billion claims per year. This equates to:

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute

What is a RAC?

- A RAC is a CMS contractor tasked with identifying Medicare Improper Payments
- RACs are paid on a contingency fee basis
- RACs are utilized throughout the healthcare industry

RAC Legislation

- Medicare Modernization Act, Section 306: required RAC demonstration
  - Demonstration – March 2005 – March 27, 2008
- Tax Relief and Health Care Act of 2006, Section 302: requires permanent and nationwide RAC program by no later than 2010
  - Announcement of new RACs TBD
  - Implemented in all 50 states by January 1, 2010

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 its error rate
  - **Taxpayers** & future Medicare beneficiaries are protected

RAC Tasks

- RACs are tasked with:
  - Detecting Medicare Improper Payments
  - Correcting Improper Payments
    - Collect overpayments from providers
    - Pay back underpayments to providers

RAC Look Back Period

- RACs will be able to look back 3 years from the date the claim was paid
- RACs will not be able to review claims paid prior to October 1, 2007

How RACs Select Claims

- RACs choose areas of focus based on data mining techniques, OIG & GAO reports, CERT reports and the experience and knowledge of staff
- Two types of review (depending on certainty)
  - Automated (no medical record) – Certainty
  - Complex (medical records reviewed within 60 days)- No certainty
- New Issues for review will be posted to RACs website

RAC Review Process

- Use same Medicare policies as FIs, Carriers and MACs: NCDs, LCDs & CMS manuals

- Use same types of staff as FIs, Carriers and MACs: nurses, therapists, certified coders & physician CMD

Requesting Medical Records

- RACs must pay for inpatient hospital records
  - Not required to pay for others
- Failure to submit requested record in 45 days = denial
- RACs will send letters requesting medical records like FI/Carrier & CERT
- CMS will establish medical record limits
- Web based application will allow address customization

Collection Process

- RAC collection process is the same as the regular collection process except:
  - New notification letter for Part A claims

Period of Discussion

- Each RAC will offer a 15 day period of discussion to providers
- Upon receipt of the demand letter the provider will be able to provide additional information to the RAC to support their claim

Appeal Process

- Same as the regular appeal process except:
  - Inpatient hospital claim appeal goes to FI (not QIO)

4th level of appeal – DAB

↑

3rd level of appeal – ALJ

↑

2nd level of appeal – QIC

↑

1st level of appeal – FI/Carrier/MAC

Ensuring Accurate Decisions

- New Issue Review
  - CMS will review all new issues proposed for review by the RAC
- Validation Process
  - Validation Contractor will review a random sample of each RACs completed reviews
  - CMS will release an accuracy score for each RAC on an annual basis
- Appeal Process
  - If RAC loses on any level of appeal, RAC pays back contingency fee

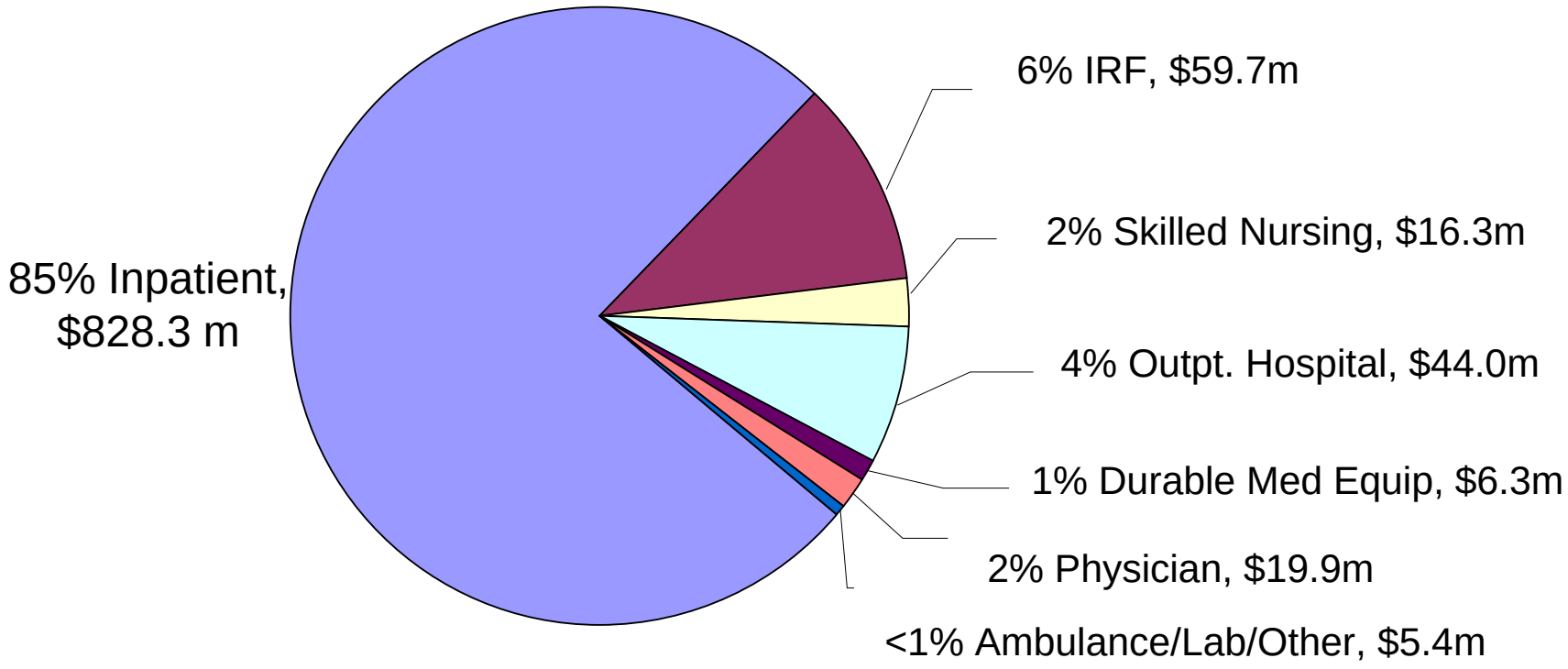
Demonstration Findings
March 2005 – March 2007

Overpmts Collected:		$992.7 m
Less Underpmts Repaid:	-	($37.8 m)
Less $ Overturned on Appeal:	-	($46.0 m)
Less PRG IRF Re-review:	-	($14.0 m)
Less Costs to Run Demo:	-	($201.3 m)
BACK TO TRUST FUNDS	→	**$693.6 m**

From the inception through March 27, 2008, the RAC demonstration spent only 20 cents for each dollar collected.

Results of the Demonstration:

Most overpayments were collected from inpatient hospitals

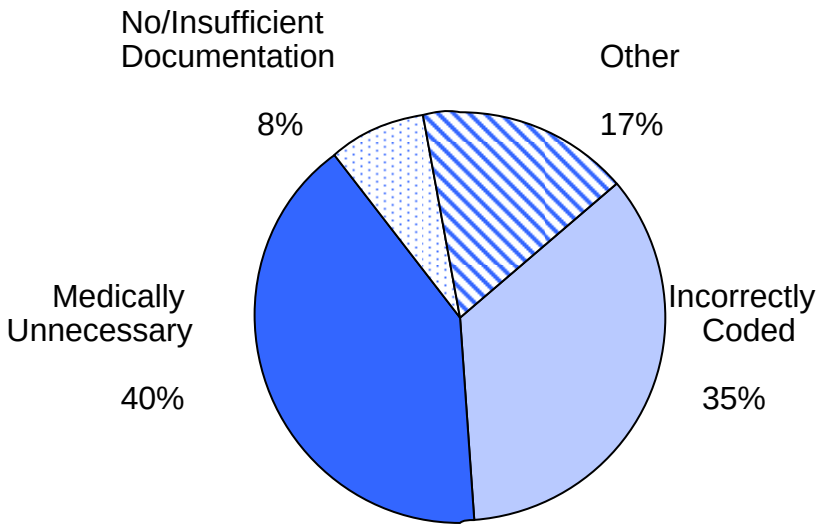


SOURCE: RAC Data Warehouse

Overpayments Collected by Error Type March 2005 – March 2007

(Net of Appeals)

- Most improper payments occur when providers submit claims that don't comply with Medicare coding rules or medical necessity guidelines



RAC Findings Are Similar to CERT Findings

CERT found that:

- 25.6% of the error rate was due to No/Insufficient Documentation errors
- 33.3% of the error rate was due to Medically Unnecessary errors
- 38.4% of the error rate was due to Incorrect Coding errors
- 5.1% of the error rate was due to Other errors

SOURCE: Self-reported by RACs

Service Specific Examples of Medically Unnecessary Service/Setting

- Excessive Units
  - Hospital submits one claim for 3 colonoscopies (for the exact same location of the colon) for same beneficiary on same day (overpayment for dollar value of 2nd & 3rd colonoscopies)
  - Physician claim for 6 vials of Neulasta when patient only needed or received 6 milligrams of Neulasta (overpayment for dollar value of 5 vials of Neulasta)

- Very Short Stay Hospital
  - The beneficiary presents to the emergency room with shortness of breath. EKG normal. Chest x-ray rules out pneumonia. The hospital admits the beneficiary for a one day hospital stay. RAC reviews the medical record, determines there is no documentation that meets criteria for inpatient admission (overpayment for full amount of stay)

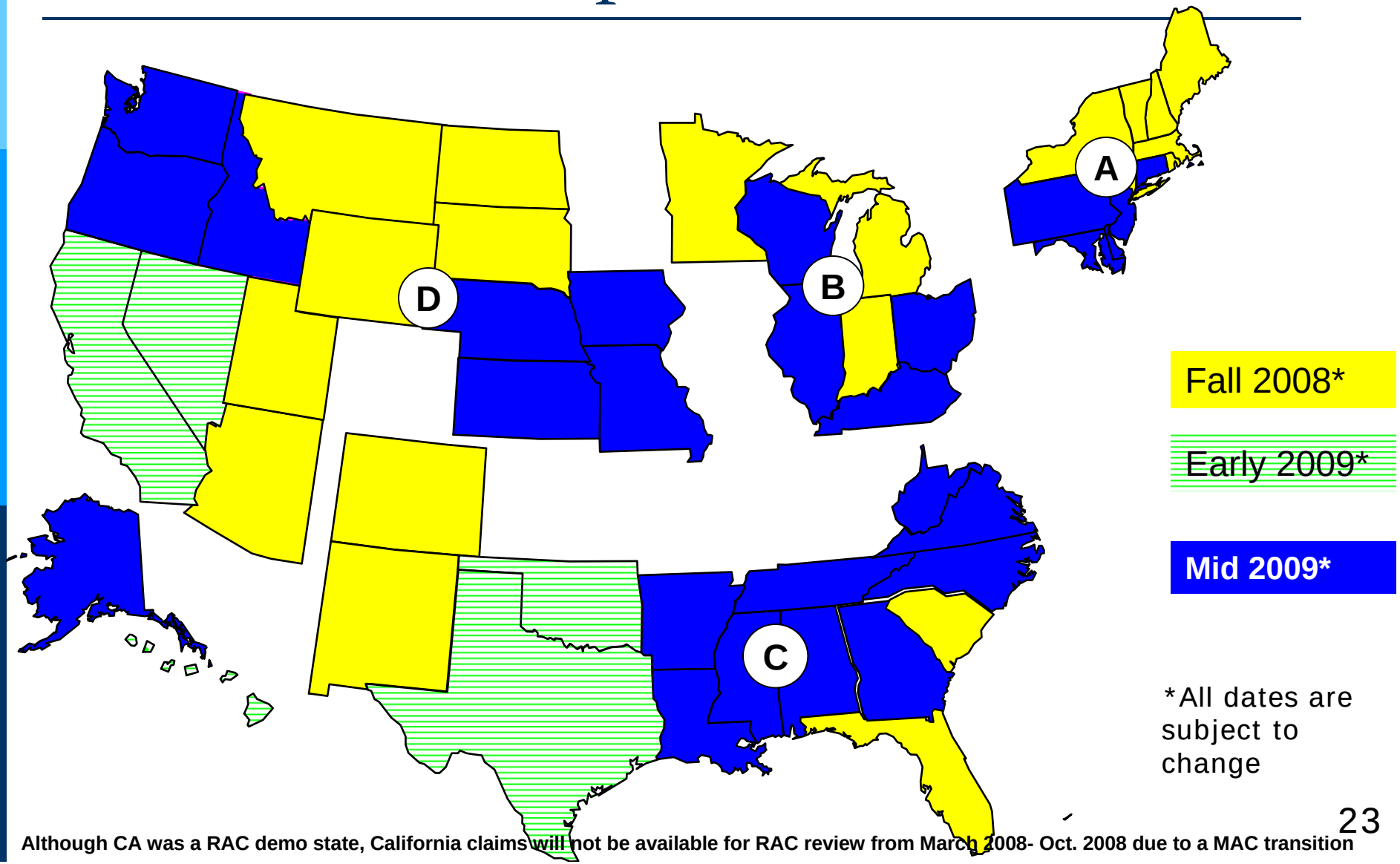
Service Specific Example of Incorrect Coding

- DRG improper up-coding for hospital care
  - Provider submits claim with “septicemia” as a diagnosis
  - The medical record shows diagnosis of urosepsis, not septicemia; blood cultures were negative
  - Had the diagnosis been coded correctly, the claim would have been paid at a lower DRG amount

Service Specific Example of Other Improper Payments

- Patient discharged from hospital with improper discharge status on claim
  - Hospital submits claim with discharge status code indicating that beneficiary was discharged to home (which gave the hospital the full DRG payment); but the beneficiary was actually transferred to another acute care inpatient hospital (which would have resulted in each hospital receiving only part of the DRG payment).
- Duplicate Claims
  - Physician submits 2 claims for same beneficiary for same service; the Medicare claims processing contractor paid both claims.

National Expansion Schedule



*All dates are subject to change

Although CA was a RAC demo state, California claims will not be available for RAC review from March 2008- Oct. 2008 due to a MAC transition

Future Enhancements to Program

- 2010
  - Web based application to see status of medical record requests/reviews
- TBD
  - Submission of electronic medical records

Key Points

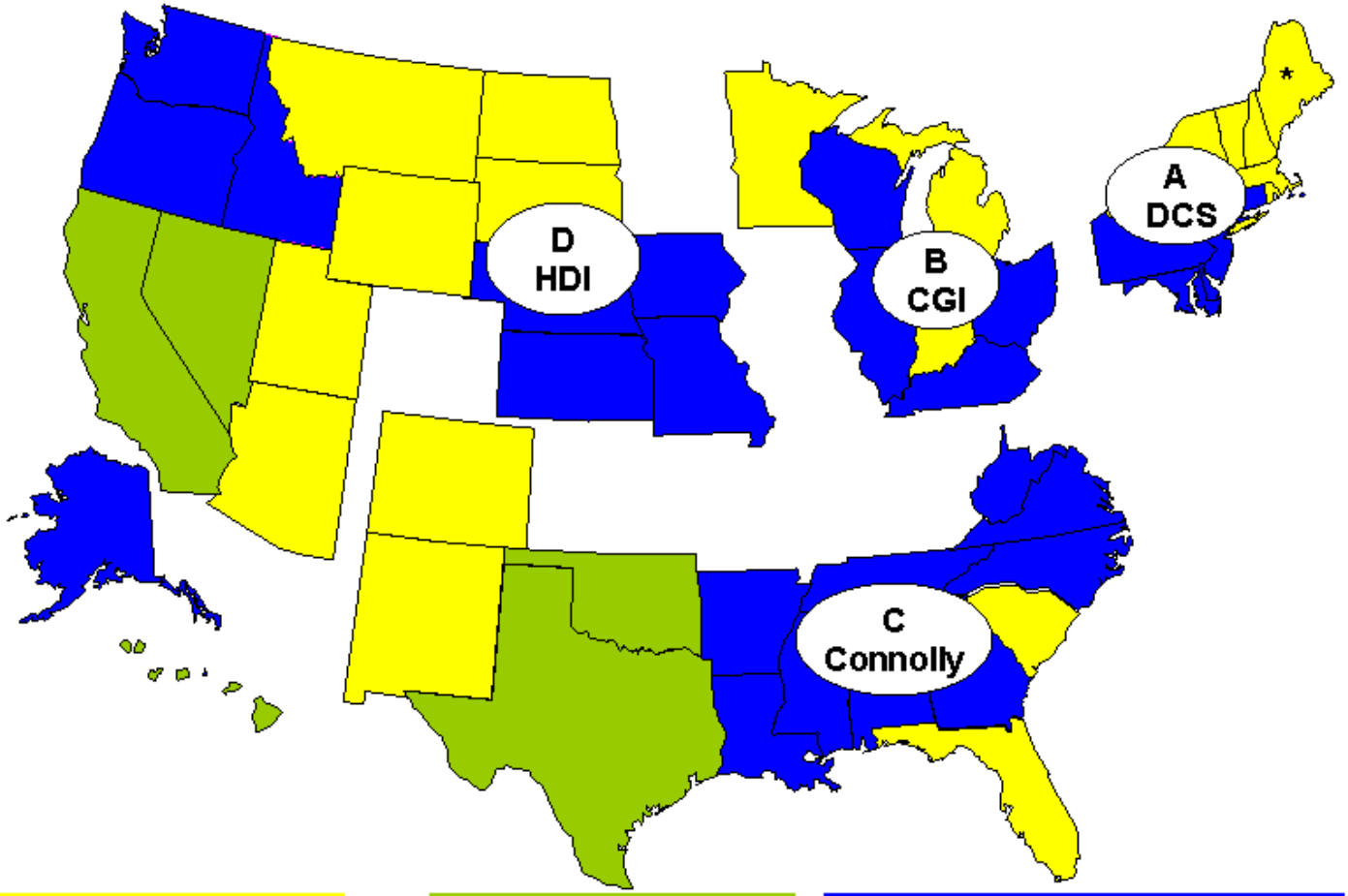
- Providers can avoid unnecessary denials by communicating precise address and contact person to RAC
- RACs use same policies as FIs, Carriers, QIOs and MACs
- CMS & RAC will have open communication with provider associations

RAC@cms.hhs.gov

"It is critical that we ensure every dollar is spent wisely so that the program is affordable for taxpayers and future generations of beneficiaries."

--Kerry Weems, CMS Administrator

RAC Phase In Schedule



March 1, 2009

March 1, 2009

August 1, 2009 or later

Statement of Work for the Recovery Audit Contractor Program

I. Purpose

The RAC Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.

The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission. The identification of underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act.

This contract includes the identification and recovery of claim based improper payments. This contract does not include the identification and/or recovery of MSP occurrences in any format.

This contract includes the following tasks which are defined in detail in subsequent sections of this contract:

1. Identifying Medicare claims that contain underpayments for which payment was made under part A or B of title XVIII of the Social Security Act.

2. Identify and Recouping Medicare claims that contain overpayments for which payment was made under part A or B of title XVIII of the Social Security Act. This includes corresponding with the provider.

3. For any RAC-identified overpayment that is appealed by the provider, the RAC shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court.

4. For any RAC identified vulnerability, support CMS in developing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future.

5. Performing the necessary provider outreach to notify provider communities of the RAC's purpose and direction.

NOTE: The proactive education of providers about Medicare coverage and coding rules is NOT a task under this RAC statement of work. CMS has tasked FIs, Carriers, and MACs with the task of proactively educating providers about how to avoid submitting a claim containing a request for an improper payment.

II. Background

Statutory Requirements

Section 302 of the Tax Relief and Health Care Act of 2006 requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize RACs under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.

CMS is required to actively review Medicare payments for services to determine accuracy and if errors are noted to pursue the collection of any payment that it determines was in error. To gain additional knowledge potential bidders may research the following documents:

- The Financial Management Manual and the Program Integrity Manual (PIM) at www.cms.hhs.gov/manuals
- The Debt Collection Improvement Act of 1996
- The Federal Claims Collection Act, as amended and related regulations found in 42 CFR.
- Comprehensive Error Rate Testing Reports (see www.cms.hhs.gov/cert)
- RAC Status Document (see www.cms.hhs.gov/rac)

Throughout this document, the term "improper payment" is used to refer collectively to overpayments and underpayments. Situations where the provider submits a claim containing an incorrect code but the mistake does not change the payment amount are NOT considered to be improper payments.

III. Transitions from Outgoing RAC to Incoming RAC

From time to time in the RAC program, transitions from one RAC to another RAC will need to occur (e.g., when the outgoing demonstration RACs cease work and the new incoming permanent RACs begin work). It is in the best interest of all parties that these transitions occur smoothly.

The transition plan will include specific dates with regard to requests for medical records, written notification of an overpayment, any written correspondence with providers and phone communication with providers. The transition plan will be communicated to all affected parties (including providers) by CMS within 60 days of its enactment.

IV. Specific Tasks

Independently and not as an agent of the Government, the Contractor shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the Government, as needed to perform the Statement of Work.

CMS will provide minimum administrative support which may include standard system changes when appropriate, help communicating with Medicare contractors, policies interpretations as necessary and other support deemed necessary by CMS to allow the RACs to perform their tasks efficiently. CMS will support changes it determines are necessary but cannot guarantee timeframes or constraints. In changing systems to support greater efficiencies for CMS, the end product could result in an administrative task being placed on the RAC that was not previously. These administrative tasks will not extend from the tasks in this contract and will be applicable to the identification and recovery of the improper payment.

Task 1- General Requirements

A. Initial Meeting with PO and CMS Staff

Project Plan - The RAC's key project staff (including overall Project Director and key sub Project Directors) shall meet in Baltimore, Maryland with the PO and relevant CMS staff within two weeks of the date of award (DOA) to discuss the project plan. The specific focus will be to discuss the time frames for the tasks outlined below. Within 2 weeks of this meeting, the RAC will submit a formal project plan, in Microsoft Project, outlining the resources and time frame for completing the work outlined. It will be the responsibility of the RAC to update this project plan. The initial project plan shall be for the base year of the contract. The project plan shall serve as a snapshot of everything the RAC is identifying at the time. As new issues rise the project plan shall be updated.

The project plan shall include the following:

1. **Detailed quarterly projection by vulnerability issue** (e.g. excisional debridement) including: a) incorrect procedure code and correct procedure code; b) type of review (automated, complex, extrapolation); c) type of vulnerability (medical necessity, incorrect coding…)

2. **Provider Outreach Plan -** A base provider outreach plan shall be submitted as part of the proposal. CMS will use the base provider outreach plan as a starting point for discussions during the initial meeting. Within two weeks of the initial meeting the RAC shall submit to the CMS PO a detailed Provider Outreach Plan for the respective region. The base provider outreach at a minimum shall include potential outreach efforts to associations, providers, Medicare contractors and any other applicable Medicare stakeholders.

3. **RAC Organizational Chart -** A draft RAC Organization Chart shall be submitted as part of the proposal. The organizational chart shall

identify the number of key personnel and the organizational structure of the RAC effort. While CMS is not dictating the number of key personnel, it is CMS' opinion that one key personnel will not be adequate for an entire region. An example of a possible organizational structure would be three (3) key personnel each overseeing a different claim type (Inpatient, Physician, and DME). This is not prescriptive and CMS is open to all organizational structures. A detailed organizational chart extending past the key personnel shall be submitted within two weeks of the initial meeting.

B. Monthly Conference Calls

A minimum of two monthly conference calls to discuss the RAC project will be necessary.

1. On a monthly basis the RAC's key project staff will participate in a conference call with CMS to discuss the progress of the work, evaluate any problems, and discuss plans for immediate next steps of the project. The RAC will be responsible for setting up the conference calls, preparing an agenda, documenting the minutes of the meeting and preparing any other supporting materials as needed.

2. On a monthly basis the RAC's key project staff will participate in a conference call with CMS to discuss findings and process improvements that will facilitate CMS in paying claims accurately in the future. CMS will be responsible for setting up the conference calls, preparing an agenda, documenting the minutes of the meeting and preparing any other supporting materials as needed.

   At CMS' discretion conference calls may be required to be completed more frequently. Also, other conference calls may be called to discuss individual items and/or issues.

C. Monthly Progress Reports

1. The RAC shall submit monthly administrative progress reports outlining all work accomplished during the previous month. These reports shall include the following:

1. Complications Completing any task
2. Communication with FI/Carrier/MAC/DME MAC/DME PSC/PSC
3. Upcoming Provider Outreach Efforts
4. Update of Project Plan
5. Update of what vulnerability issues are being reviewed in the next month
6. Recommended corrective actions for vulnerabilities (i.e. LCD change, system edit, provider education…)

7. Update on how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies
8. Update on JOAs
9. Action Items
10. Appeal Statistics
11. Problems Encountered
12. Process Improvements to be completed by RAC

    At CMS discretion a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

2. The RAC shall submit monthly financial reports outlining all work accomplished during the previous month. This report shall be broken down into eight categories:

    a. Overpayments Collected- Amounts shall only be on this report if the amount has been collected by the FI/Carrier/MAC/DME MAC (in summary and detail)
    b. Underpayments Identified and Paid Back to Provider- Amounts shall only be on this report if the amount has been paid back to the provider by the FI/Carrier/MAC/DME MAC (in summary and detail)
    c. Overpayments Adjusted- Amounts shall be included on this report if an appeal has been decided in the provider's favor or if the RAC rescinded the overpayment after adjustment occurred (in summary and detail)
    d. Overpayments In the Queue- This report includes claims where the RAC believes an overpayment exists because of an automated or complex review but the amount has not been recovered by the FI/Carrier/MAC/DME MAC yet
    e. Underpayments In the Queue- This report includes claims where the RAC believes an underpayment exists because of an automated or complex review but the amount has not been paid back to the provider yet
    f. Number of medical records requested from each provider (in detail)
    g. Number of medical reviews completed within 60 days
    h. Number of reviews that failed to meet the 60 day review timeframe and the rationale for failure to complete the reviews within 60 days

    Reports a, b and c in #3 above shall also be included with the monthly voucher to CMS.

    All reports shall be in summary format with all applicable supporting documentation.

    At CMS discretion a standardized monthly report(s) may be required. If a standardized monthly report is required, CMS will provide the format.

Each monthly report shall be submitted by the close of business on the fifth business day following the end of the month by email to the CMS PO and one copy accompanying the contractor's voucher that is sent to the CMS accounting office.

D. RAC Data Warehouse

CMS will provide access to the RAC Data Warehouse. The RAC Data Warehouse is a web based application which houses all RAC identifications and collections. The RAC Data Warehouse includes all suppressions and exclusions. Suppressions and exclusions are claims that are not available to the RAC for review. The RAC will be responsible for providing the appropriate equipment so that they can access the Data Warehouse.

E. Geographic Region

The claims being analyzed for this award will be claims from providers with originating addresses in Region ____ (or debts associated with claims, as applicable) appropriately submitted to carriers, intermediaries, MACs or DME MACs in Region ____ or Mutual of Omaha.

CMS will have four (4) regions. There will be one (1) RAC in each region. Each RAC will perform recovery audit services for all claim types in that region. A map of the regions can be found in Appendix 2.

Task 2- Identification of Improper Payments

Identification of Medicare Improper payments

The RAC(s) shall pursue the identification of Medicare claims which contain improper payments for which payment was made or should have been made under part A or B of title XVIII of the Social Security Act. RACs are required to comply with Reopening Regulations located at 42 CFR 405.980. Before a RAC makes a decision to reopen a claim, the RAC must have good cause. Additionally, RACs shall ensure that processes are developed to minimize provider burden to the greatest extent possible when Identifying Medicare Improper payments.

A. Improper payments INCLUDED in this Statement of Work

Unless prohibited by Section 2B, the RAC may attempt to identify improper payments that result from any of the following:

- Incorrect payment amounts
  (exception: in cases where CMS issues instructions directing contractors to not pursue certain incorrect payments made)
- Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act),
- Incorrectly coded services (including DRG miscoding)
- Duplicate services

The RAC may attempt to identify improper payments on claims (including inpatient hospital claims)—

- Paid by carriers, intermediaries, MACs and DME MACs with jurisdiction in Region ____

B. Improper payments EXCLUDED from this Statement of Work

The RAC may NOT attempt to identify improper payments arising from any of the following:

1. Services provided under a program other than Medicare Fee-For-Service

For example, RACs may NOT attempt to identify improper payments in the Medicare Managed Care program, Medicare drug card program or drug benefit program.

2. Cost report settlement process

RACs may NOT attempt to identify underpayments and overpayments that result from Indirect Medical Education (IME) and Graduate Medical Education (GME) payments.

3. Claims more than 3 years past the date of the initial determination

The RAC shall not attempt to identify any overpayment or underpayment more than 3 years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date. Any overpayment or underpayment inadvertently identified by the RAC after this timeframe shall be set aside. The RAC shall take no further action on these claims except to indicate the appropriate status code on the RAC Data Warehouse. The look back period is counted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex reviews) or the date of the overpayment notification letter (for automated reviews).

Note: CMS reserves the right to limit the time period available for RAC review by RAC, by region/state, by claim type, by provider type, or by any other reason where CMS believes it is in the best interest of the Medicare program to limit claim review. This notice will be in writing, may be by email and will be effective immediately.

4. Claim paid dates earlier than October 1, 2007

The RAC program will begin with claims paid on or after October 1, 2007. This begin date will be for all states. The actual start date for a RAC in a state will not change this date. As time passes, the RAC may look back 3 years but the claim paid date may never be earlier than October 1, 2007. In other words the RAC will only look at FY 2008 claims and forward. The RAC will not review claims prior to FY 2008 claim paid dates.

For example, in the state of New York a RAC will be "live" in March 2008. In March 2008, the New York RAC will be able to review claims with paid dates from October 1, 2007- March 2008. In December 2008, the New York RAC will be able to review claims with paid dates from October 1, 2007- December 2008.

Another example, in the state of Pennsylvania a RAC will not be "live" until January 2009 (or later). In January 2009, if the RAC is "live," the RAC in Pennsylvania will be able to review claims from October 1, 2007- January 2009.

5. Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment

The RAC shall not attempt to identify any overpayment where the provider is without fault with respect to the overpayment. If the provider is without fault with respect to the overpayment, liability switches to the beneficiary. The beneficiary would be responsible for the overpayment and would receive the demand letter. The RAC may not attempt recoupment from a beneficiary. One example of this situation may be a service that was not covered because it was not reasonable and necessary but the beneficiary signed an Advance Beneficiary Notice. Another example of this situation is benefit category denials such as the 3 day hospital stay prior to SNF admission.

Chapter 3 of the PIM and HCFA/CMS Ruling #95-1 explain Medicare liability rules. Without fault regulations can be found at 42 CFR 405.350 and further instructions can be found in Chapter 3 of the Financial Management Manual.

In addition, a provider can be found without fault if the overpayment was determined subsequent to the third year following the year in which the claim was paid. Providers may appeal an overpayment solely based on the without fault regulations.
Therefore, the RAC shall not identify an overpayment if the provider can be found without fault. Examples of this regulation can be found in IOM Publication 100-6, Chapter 3, and Section 100.7.

6. Random selection of claims

The RAC shall adhere to Section 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which prohibits the use of random claim selection for any purpose other than to establish an error rate. Therefore, the

RAC shall not use random review in order to identify cases for which it will order medical records from the provider. Instead, the RAC shall utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called "targeted review". The RAC may not target a claim solely because it is a high dollar claim but may target a claim because it is high dollar AND contains other information that leads the RAC to believe it is likely to contain an overpayment.

NOTE: The above paragraph does not preclude the RAC from utilizing extrapolation techniques for targeted providers or services.

7. Claims Identified with a Special Processing Number

Claims containing Special Processing Numbers are involved in a Medicare demonstration or have other special processing rules that apply. These claims are not subject to review by the RAC. CMS attempts to remove these claims from the data prior to transmission to the RACs.

8. Prepayment Review

The RAC shall identify Medicare improper payments using the post payment claims review process. Any other source of identification of a Medicare overpayment or underpayment (such as prepayment review) is not included in the scope of this contract.

C. Preventing Overlap

1. Preventing overlap with contractor performing claim review and/or responsible for recoveries.

In order to minimize the impact on the provider community, it is critical that the RAC avoids situations where the RAC and another entity (Medicare contractor, PSC, MAC or law enforcement) are working on the same claim.
Therefore, the RAC Data Warehouse will be used by the RAC to determine if another entity already has the provider and/or claim under review. The RAC Data Warehouse will include a master table of excluded providers and claims. This table will be updated on an as needed basis. Before beginning a claim review the RAC shall utilize the RAC Data Warehouse to determine if exclusion exists for that claim. If exclusion exists for that claim, the RAC is not permitted to review that claim. If the exclusion is entered after the RAC begins its review, the RAC and CMS will be notified so that the RAC can cease all activity.

Definition of Exclusions - An excluded claim is a claim that has already been reviewed by another entity. This includes claims that were originally denied and then paid on appeal. Only claims may be excluded. Providers may not be excluded. Exclusions are permanent. This means that an excluded claim will

never be available for the RAC to review.

The following contractors may input claims into the master table for exclusion:

- Part B physician or supplier claims: the carrier or MAC medical review unit for the state.
- Part A claims (other than inpatient PPS hospital claims and long term care hospital claims): the intermediary or MAC medical review unit for the state.
- Part A inpatient PPS hospital claims and long term hospital claims: MAC for the state.
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies: the appropriate DME MAC/PSC medical review unit for that state.
- Comprehensive Error Rate Testing (CERT) Contractor
- CMS RAC Project Officer

2. ***Preventing RAC overlap with contractors, CMS, OGC, DOJ, OIG and/or other law enforcement entities performing potential fraud reviews.***

CMS must ensure that RAC activities do not interfere with potential fraud reviews being conducted by Benefit Integrity (BI) Program Safeguard Contractors (PSCs) or DMERC BI units or with potential fraud investigations being conducted by law enforcement. Therefore, RACs shall input all claims into the RAC Data Warehouse before attempting to identify or recover overpayments. (The master table described above will be utilized.)

Definition of Suppression - A suppressed provider and/or claim is a provider and/or claim that are a part of an ongoing investigation. Normally, suppressions will be temporary and will ultimately be released by the suppression entity.

The following contractors may input providers and/or claims into the master table for suppression:

- Part B physician or supplier claims: the appropriate PSC, OIG, or law enforcement entity
- Part A claims (other than inpatient PPS hospital claims and long term care hospital claims): the appropriate PSC, OIG, or law enforcement entity
- Part A inpatient PPS hospital claims and long term hospital claims: the

appropriate PSC, OIG, or law enforcement entity

- CMS RAC Project Officer
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies: the appropriate PSC, OIG or law enforcement entity

D. Obtaining and Storing Medical Records for reviews

Whenever needed for reviews, the RAC may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the RAC. (Securely transmit means sent in accordance with the CMS business systems security manual – e.g., mailed CD, MDCN line, through a clearinghouse)

If the RAC attempts an onsite visit and the provider refuses to allow access to their facility, the RAC may not make an overpayment determination based upon the lack of access. Instead, the RAC shall request the needed records in writing.

When onsite review results in an improper payment finding, the RAC shall copy the relevant portions of the medical record and retain them for future use. When onsite review results in no finding of improper payment, the RAC need not retain a copy of the medical record.

When requesting medical records the RAC shall use discretion to ensure the number of medical records in the request is not negatively impacting the provider's ability to provide care. Before contract award CMS will institute a medical record request limit. Different limits may apply for different provider types and for hospitals the limit may be based on size of the hospital (number of beds). The limit would be per provider location and type per time period. An example of a medical record limit would be no more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45 day time period. CMS may enact a different limit for different claim types (outpatient hospital, physicians, supplier, etc). The medical record request limit may also take into account a hospital's annual Medicare payments.

The medical record request limit may not be superceded by bunching the medical record requests. For example, if the medical record request limit for a particular provider is 50 per month and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

All Medical Request letters must adequately describe the good cause for reopening the claim. Good cause for reopening the claim may include but is not limited to OIG report findings, data analysis findings, comparative billing analysis, etc.

The RAC shall develop a mechanism to allow providers to customize their address and point of contact (e.g. Washington County Hospital, Medical Records Dept.,

attention: Mary Smith, 123 Antietam Street, Gaithersburg, MD 20879). By January 01, 2010 all RACs shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS Project Officer. RACs may visit the CERT Contractor's address customization website at http://www.certcdc.com/certproviderportal/verifyaddress.aspx for an example of a simple but successful system. Each medical record request must inform the provider about the existence of the address customization system.

NOTE: The RAC is encouraged to solicit and utilize the assistance of provider associations to help collect this information and house it in an easily updatable database.

1. ***Paying for medical records***

   a. *RACs shall pay for medical records.*

   Should the RAC request medical records associated with:

   - an acute care inpatient prospective payment system (PPS) hospital (DRG) claim,
   - A Long Term Care hospital claim, the RAC shall pay the provider for producing the records in accordance with the current formula or any applicable payment formula created by state law. (The current per page rate is: medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement. Capitation providers such as HMOs and dialysis facilities receive $.12 per page. RACs shall comply with the formula calculation found at 42 CFR §476.78(c). RACs shall also ensure compliance with any changes that are made to the formula calculation or rate in future publications of the Federal Register.)

   RACs are required to pay for copying of the inpatient (PPS) and Long Term Care hospital medical records on at least a monthly basis. For example, a RAC may choose to issue checks on the 10th of the month for all medical records received the previous month. All checks should be issued within 45 days of receiving the medical record.

   RACs 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. RACs must remain capable of accepting faxed or paper medical records indefinitely.

   RACs shall pay the same per page rate for the production of imaged or electronic medical records. RACs must ensure that providers/clearinghouses

first successfully complete a connectivity and readability test with the RAC system before being invited to submit imaged or electronic records to the RAC. The RAC must comply with all CMS business system security requirements.

b. *RACs <u>may</u> pay for medical records.*

Should the RAC request medical records associated with any other type of claim including but not limited to the facilities listed in PIM 1.1.2, paragraph 2, the RAC may (but is not required to) pay the provider for producing the record using any formula the RAC desires.

2. ***Updating the Case File***

The RAC shall indicate in the case file (See Task 7; section G for additional case record maintenance instructions.)

- A copy of all request letters,
- Contacts with ACs, CMS or OIG,
- Dates of any calls made, and
- Notes indicating what transpired during the call.

<u>Communication and Correspondence with Provider- Database</u>

To assess provider reaction to the RACs and the RAC Program, CMS will complete regular surveys with the provider community. To help determine the universe of providers contacted by a RAC, the RAC will have to supply a listing of all providers to CMS and/or the evaluation contractor. CMS encourages the RAC to utilize an electronic database for all communication and correspondence with the provider. This ensures tracking of all communication and allows for easy access for customer service representatives. This also allows for easy transmission to CMS in the event of an audit or when the listing for the surveys is due. CMS expects the listing to be due no less than twice a year.

3. ***Assessing an overpayment for failing to provide requested medical record.***

Pursuant to the instructions found in PIM 3.10 and Exhibits 9-12, the RAC may find the claim to be an overpayment if medical records are requested and not received within 45 days. Prior to denying the claim for failure to submit documentation the RACs shall initiate one additional contact before issuing a denial.

4. ***Storing and sharing medical records***

The RAC must make available to all ACs, CMS, QICs, OIG, (and others as indicated by the PO) any requested medical record via a MDCN line.

Storing and sharing IMAGED medical records

The RAC shall, on the effective date of this contract, be prepared to store and share imaged medical records. The RAC shall:

- Provide a document management system
- Store medical record NOT associated with an overpayment for 1 year,
- Store medical records associated with an overpayment for duration of the contract,
- Maintain a log of all requests for medical records indicating at least the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled. The RAC Data Warehouse will not be available for this purpose. The RAC shall make information about the status of a medical record (outstanding, received, review underway, review complete, case closed) available to providers upon request. By January 01, 2010 all RACs shall develop a web-based application for this purpose. All web-based applications shall be approved by the CMS Project Officer.

For purposes of this section sharing imaged medical records means the transmission of the record on a disk, CD, DVD, FTP or MDCN line. PHI shall not be transmitted through any means except a MDCN line, postal mail, overnight courier or a fax machine.

Upon the end of the contract, the RAC shall send copies of the imaged records to the contractor specified by the PO.

E. The Claim Review Process

1. *Types of Determinations a RAC may make*

When a RAC reviews a claim, they may make any or all of the determinations listed below.

a. Coverage Determinations

The RAC may find a full or partial overpayment exists if the service is not covered (i.e., it fails to meet one or more of the conditions for coverage listed below).

In order to be covered by Medicare, a service must:

i. Be included in one of the benefit categories described in Title XVIII of the Act;

ii. Not be excluded from coverage on grounds other than 1862(a)(1); and

iii. Be reasonable and necessary under Section 1862(a)(1) of the Act. The RAC shall consider a service to be reasonable and necessary if the RAC determines that the service is:

A. Safe and effective;

B. Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and

C. Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
- Furnished in a setting appropriate to the patient's medical needs and condition;
- Ordered and furnished by qualified personnel;
- One that meets, but does not exceed, the patient's medical need; and
- At least as beneficial as an existing and available medically appropriate alternative.

There are several exceptions to the requirement that a service be reasonable and necessary for diagnosis or treatment of illness or injury. The exceptions appear in the full text of §1862(a) (1) (A) and include but are not limited to:

- Pneumococcal, influenza and hepatitis B vaccines are covered if they are reasonable and necessary for the prevention of illness;
- Hospice care is covered if it is reasonable and necessary for the palliation or management of terminal illness;
- Screening mammography is covered if it is within frequency limits and meets quality standards;
- Screening pap smears and screening pelvic exam are covered if they are within frequency limits;
- Prostate cancer screening tests are covered if within frequency limits;
- Colorectal cancer screening tests are covered if within frequency limits; and
- One pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an interlobular lens.

RACs must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

Limitation of Liability Determinations
If a RAC identifies a full or partial overpayment because an item or service is not reasonable and necessary, the RAC shall make and document §§1879, 1870, and 1842(l) (limitation of liability) determinations as appropriate. Because these determinations can be appealed, it is important that the rationale for the determination be documented both initially and at each level of appeal. Limitation of Liability determinations do not apply to denials based on determinations other than reasonable and necessary. See PIM Exhibits 14 - 14.3 for further details.

b. Coding Determinations

The RAC may find that an overpayment or underpayment exists if the service is not correctly coded (i.e., it fails to meet one or more of the coding requirements listed in an NCD, local coding article, Coding Clinic, CPT or CPT Assistant.)

c. Other Determinations

The RAC may determine that an overpayment or underpayment exists if the claim was paid twice (i.e., a "duplicate claim"), was priced incorrectly, or the claims processing contractor did not apply a payment policy (e.g., paying the second surgery at 50% of the fee schedule amount).

2. Minor Omissions

Consistent with Section 937 of the MMA, the RAC shall not make denials on minor omissions such as missing dates or signatures.

3. Medicare Policies and Articles

The RAC shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (LCDs) (formerly called local medical review policies (LMRPs)) and local coverage/coding articles in their jurisdiction. NCDs, LMRPs/LCD and local coverage/coding articles can be found in the Medicare Coverage Data Warehouse http://www.cms.hhs.gov/mcd/overview.asp). Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the RAC shall comply with all relevant joint signature memos forwarded to the RAC by the project officer.
RACs should not apply a LCD retroactively to claims processed prior to the effective date of the policy. RAC shall ensure that policies utilized in making a

review determination are applicable at the time the service was rendered except in the case of a retroactively liberalized LCDs or CMS National policy.

The RAC shall keep in mind that not all policy carriers the same weight in the appeals process. For example, ALJs are not bound by LCDs but are bound by NCDs and Rulings.

If an issue is brought to the attention of CMS by any means and CMS instructs the RAC on the interpretation of any policy and/or regulation, the RAC shall abide by CMS' decision.

4. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the RAC shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Internal Guidelines." Internal Guidelines, in essence, will allow the RAC to operationalize carrier and intermediary LCDs and NCDs. Internal Guidelines shall specify what information should be reviewed by reviewers and the appropriate resulting determination. The RAC need not hold public meetings or seek public comments on their proposed internal guidelines. However, they must make their Internal Guidelines available to CMS upon request. Internal Guidelines shall not create or change policy.

5. Administrative Relief from Review in the Presence of a Disaster

The RAC shall comply with PIM 3.2.2 regarding administrative relief from review in the presence of a disaster.

6. Evidence

The RAC shall only identify a claims overpayment where there is supportable evidence of the overpayment. There are two primary ways of identification:

a) Through "automated review" of claims data without human review of medical or other records; and
b) Through "complex review" which entails human review of a medical record or other documentation.

7. Automated Review vs. Complex Review

a. **Automated Review.** Automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record.

i. <u>Coverage/Coding Determinations Made Through Automated Review</u>
The RAC may use automated review when making coverage and coding determinations only where BOTH of the following conditions apply:

- there is certainty that the service is not covered or is incorrectly coded, AND
- a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline (e.g., CPT statement, CPT Assistant statement, Coding Clinic statement, etc.) exists

When making coverage and coding determinations, if no **certainty** exists as to whether the service is covered or correctly coded, the RAC shall not use automated review. When making coverage and coding determinations, if no written **Medicare policy, Medicare article, or Medicare-sanctioned coding guideline** exists, the RAC shall not use automated review. Examples of Medicare-sanctioned coding guidelines include: CPT statements, CPT Assistant statements, and Coding Clinic statements.)

EXCEPTION: If the RAC identifies a "clinically unbelievable" issue (i.e., a situation where certainty of noncoverage or incorrectly coding exists but no Medicare policy, Medicare articles or Medicare-sanctioned coding guidelines exist), the RAC may seek CMS approval to proceed with automated review. Unless or until CMS approves the issue for automated review, the RAC must make its determinations through complex review.

ii. Other Determinations Made Through Automated Review

The RAC may use automated review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often don't exist for these situations.

b. **Complex Review**. Complex review occurs when a RAC makes a claim determination utilizing human review of the medical record. The RAC may use complex review in situations where the requirements for automated review are not met or the RAC is unsure whether the requirements for automated review are met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered or where no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists. Complex copies of medical records will be needed to provide support for the overpayment.

c. **Summary of Automated vs. Complex.** The chart below summarizes these requirements.

Complex Review (with medical record)		**Automated (without medical record)**			
		Coverage/Coding Determinations		**Other Determinations** (duplicates, pricing mistakes, etc)	
Written	No written	Written Medicare	No written Medicare	Certainty	NO

Medicare policy/article or Medicare-sanctioned coding guidelines exists	Medicare policy/article or Medicare-sanctioned coding guidelines exists	policy/article or Medicare-sanctioned coding guidelines exists		policy/article or Medicare-sanctioned coding guidelines exists		exists	Certainty exists
		Certainty exists	NO Certainty exists	Certainty exists	NO Certainty exists		
Allowed	**Allowed** (often called "Individual Claim Determinations")	**Allowed**	**Not allowed**	**Allowed with prior CMS approval** (often called "clinically unbelievable" situations)	**Not allowed**	**Allowed**	**Not allowed**

8. Individual Claim Determinations

The term "individual claim determination" refers to a complex review performed by a RAC in the absence of a written Medicare policy, article, or coding statement. When making individual claim determinations, the RAC shall utilize appropriate medical literature and apply appropriate clinical judgment. The RAC shall consider the broad range of available evidence and evaluate its quality before making individual claim determinations. The extent and quality of supporting evidence is key to defending challenges to individual claim determinations. Individual claim determinations which challenge the standard of practice in a community shall be based on sufficient evidence to convincingly refute evidence presented in support of coverage. The RAC shall ensure that their CMD is actively involved in examining all evidence used in making individual claim determinations and acting as a resource to all reviewers making individual claim determinations.

9. Staff Performing Complex Coverage/Coding Reviews

Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the RAC shall ensure that coverage/medical necessity determinations are made by RNs or therapists and that coding determinations are made by certified coders. The RAC shall ensure that no nurse, therapist or coder reviews claims from a provider who was their employer within the previous 12 months. RACs shall maintain and provide documentation upon the provider's request the credentials of the individuals making the medical review determinations. If the provider requests to speak to the CMD regarding a claim(s) denial the RAC shall ensure the CMD participates in the discussion.

10. Timeframes for Completing Complex Coverage/Coding Reviews

RACs shall complete their complex reviews within 60 days from receipt of the medical record documentation. RACs may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extended timeframe for review is granted RACs shall notify the provider in writing or via a web-based application of the situation that has resulted in the delay and will indicate

that the Notification of Findings will be sent once CMS approves the RAC moving forward with the review.

11. Re-openings of Claims Denied Due to Failure to Submit Necessary Medical Documentation (remittance advice code N102 or 56900)

In cases where the RAC denies a claim with remittance advice code N102 or 56900 ("This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.") and the denial is appealed, the appeals department **may, at CMS direction,** send the claim to the RAC for reopening under certain conditions, listed in CMS Pub. IOM 100-04, chapter 34, §10.3. If this occurs, the RAC shall conduct a reopening of claims sent by the appeals department within **30 days** of receipt of the forwarded claim and requested documentation by the RAC. In addition, the RAC shall issue a new letter containing the revised denial reason and the information required by PIM chapter 3, §3.6.5.

F. Activities Following Review

1. Rationale for Determination.

The RAC shall document the rationale for the determination. This rationale shall list the review findings including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment.

The RAC shall make available upon request by any other ACs, CMS, OIG, (and others as indicated by the PO) any requested rationale.

Storing and making available IMAGED rationale documents

The RAC shall on the effective date of this contract be prepared to store and share imaged medical records. The RAC shall:

- Provide a document management system that meets CMS requirements,
- Store rationale documents NOT associated with an overpayment for 1 year,
- Store rationale documents associated with an overpayment for the duration of the contract,
- Maintain a log of all requests for rationale documents indicating at least the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled. The RAC Data Warehouse will not be available for this purpose.

Upon the end of the contract, the RAC shall send copies of the imaged rationale documents to the contractor specified by the PO.

2. Validation Process

a. Validating the Issue

RACs are encouraged to meet with the FIs, carriers, and MACs in their jurisdiction to discuss potential findings the RAC may have identified. The RAC may request that the FI/Carrier/MAC review some claims in order to validate the accuracy of the RAC determination.

b. Validating the Claims at CMS or the RAC Validation Contractor

Once the RAC has chosen to pursue a new issue that requires complex or automated review, the RAC shall notify the PO of the issue in a format to be prescribed by the PO. The PO will notify the RAC which issues have been selected for claim validation (either by CMS or by an independent RAC Validation Contractor). The RAC shall forward any requested information in a format to be prescribed by the PO. The PO will notify the RAC if/when they may begin issuing medical record request letters (beyond the 10 test claims) and demand letters on the new issue. The RAC shall not issue any demand letters on issues that have not approved by CMS. The RAC may request up to 10 medical records when developing a test case for CMS to validate. The RAC shall not issue medical record requests beyond the 10 test claims without prior PO approval. CMS or the RAC Validation Contractor may also evaluate the clarity, accuracy, and completeness of the RAC letter to providers.

3. Communication with Providers about Improper Payment Cases

The RAC may send the provider only one review results per claim. For example, a RAC may NOT send the provider a letter on January 10 containing the results of a medical necessity review and send a separate letter on January 20 containing the results of the correct coding review for the same claim. Instead, the RAC must wait until January 20 to inform the provider of the results of both reviews in the same letter. It is acceptable to send one notification letter that contains a list of all the claims denied for the same reason (i.e. all claims denied because the wrong number of units were billed for a particular drug). In situations in which the RAC identifies two different reasons for a denial, a letter should be sent for each reason identified. For example, if the RAC identified a problem with the coding of respiratory failure and denied several claim(s) because the wrong procedure code and wrong diagnosis codes were billed, the RAC should send two separate letters. The first letter should list all claims in which an improper payment was identified

that contained the wrong procedure code and the second letter should identify those denied because the wrong diagnosis code was billed.

RACs shall ensure that the date a claim was reopened (regardless of the demand letter issue date) is documented and the rationale for good cause when claims are reopened more than 12 months from date of the initial determination. Including this information will lend credibility to RAC documentation if the RAC determination is appealed. RACs shall clearly document the date the claim was reopened and the rational for good cause in the Notification of RAC Review Findings (for initial determinations made by a Part A claims processing contractor), in the demand letter (for initial determinations made by a Part B claims processing contractor) and in all case files.

a. Automated review

The RAC shall communicate to the provider the results of each automated review that results in an overpayment determination. The RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC need not communicate to providers the results of automated reviews that do not result in an overpayment determination. The RAC shall record the date and format of this communication in the RAC Data Warehouse.

b. Complex review

The RAC shall communicate to the provider the results of every complex review (i.e., every review where a medical record was obtained), including cases where no improper payment was identified. In cases where an improper payment was identified, the RAC shall inform the provider of which coverage/coding/payment policy or article was violated. The RAC shall record the date and format of this communication in the RAC Data Warehouse.

c. Contents of Notification of RAC Complex Review Findings Letter

The RAC shall send a letter to the provider indicating the results of the review within 60 days of the exit conference (for provider site reviews) or receipt of medical records (for RAC site reviews). If the RAC need more than 60 days, they are to contact the Project Officer for an extension. Each letter must include:

- Identification of the provider(s) or supplier(s)--name, address, and provider number;
- The reason for conducting the review (See Section SOW 2F-3);
- A narrative description of the overpayment situation: state the specific issues involved which created the improper payment and

any pertinent issues as well as any recommended corrective actions the provider should consider taking;
• The findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered, or incorrectly coded;
A list of all individual claims including the actual amounts determined to be noncovered, the specific reason for noncoverage, the amounts denied,
• For statistical sampling for overpayment estimation reviews, any information required by PIM, chapter 3, section 3.10.4.4;
• An explanation of the provider's or supplier's right to submit a rebuttal statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6);
• An explanation of the procedures for recovery of overpayments including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's right to request an extended repayment schedule;
• The provider appeal rights information;
• All demand letter requirements listed in Task 4, Section A-Written Notification to Provider.

4. Determine the Overpayment Amount

a. Full denials

A full denial occurs when the RAC determines that:

i. The submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or
ii. No service was provided.

The overpayment amount is the total paid amount for the service in question.

b. Partial denials

A partial denial occurs when the RAC determines that:

i. The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary, or
ii. The submitted service was upcoded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made.
iii. The AC failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

Note: Other situations that are not categorized above should be brought to

the CMS PO's attention before the RAC sends notification to the provider.

In these cases, the RAC must determine the level of service that was reasonable and necessary or represents the correct code for the service described in the medical record. In order to determine the actual overpayment amount, the claim adjustment will have to be completed by the AC. Once the AC completes the claim adjustment, the AC will notify the RAC through the RAC Data Warehouse (or another method instructed by CMS) of the overpayment amount. The RAC shall then proceed with recovery. The RAC can only collect the difference between the paid amount and the amount that should have been paid.

*How the adjustment is completed in the shared system may not necessarily correlate with the RAC contingency amount. For example, a RAC contingency amount could equate to the difference between the full denial and any services determined by CMS to be payable.

c. Extrapolation

Follow the procedures found in PIM 3.10 and Exhibits 9-12, as well as MMA Section 935(a), regarding the use of extrapolation.

d. Recording the Improper Payment Amount in the RAC Data Warehouse

The RAC shall update the RAC Data Warehouse with:

- The improper payment amount for each claim in question;
- Line level claim detail;
- The date of the original demand/notification letter;
- Appeal status;
- Collection detail and/or adjustments due to errors/appeals;
- Any other claim level information found in the RAC Data Warehouse User Guide.

Once an overpayment is identified, the RAC shall proceed with the Recovery of Medicare Overpayments.

G. Potential Fraud

The RAC shall report instances of potential fraud immediately to the CMS PO. (See Task 7 section F on recalled cases)

H. Potential Quality Problems

The RAC shall report potential quality issues immediately to the QIO. The mechanism to report potential quality issues shall be addressed in the JOA between

the RAC and the QIO. If a JOA cannot be reached with a particular QIO, the RAC shall report the potential quality issue to their CMS PO.

I. RAC Medical Director

Each RAC must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience. More than one individual's time cannot be combined to meet the one FTE minimum.

Relevant Work Experience

- Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization,
- Extensive knowledge of the Medicare program particularly the coverage and payment rules, and
- Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

Relevant Educational Experience

- Experience practicing medicine as a board certified doctor of medicine or doctor who is currently licensed.

All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties relevant to the RAC are listed below.

Primary duties include:

- Providing the clinical expertise and judgment to understand LCDs, NCDs and other Medicare policy;
- Serving as a readily available source of medical information to provide guidance in questionable claims reviews situations;
- Recommending when LCDs, NCDs, provider education, system edits or other corrective actions are needed or must be revised to address RAC vulnerabilities;
- Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
- Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;

Other duties include:

- Interacting with the CMDs at other contractors and/or RACs to share information on potential problem areas;
- Participating in CMD clinical workgroups, as appropriate; and
- Upon request, providing input to CO on national coverage and payment policy, including recommendations for relative value unit (RVU) assignments.
- Participating in CMS/RAC presentations to providers and associations

To prevent conflict of interest issues, the CMD must provide written notification to CMS within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify CMS of the type and extent of the practice.

J. Assisting CMS in the development of the Medicare Improper Payment Prevention Plan

Through monthly calls, monthly reports and databases the RAC shall assist CMS in the development of the Medicare Improper Payment Prevention Plan. The Medicare Improper Payment Prevention Plan is a listing of all RAC vulnerabilities identified that CMS may need to address through LCDs, NCDs, provider education or system edits.

K. Communication with Other Medicare Contractors

1. Joint Operating Agreement

   The RAC shall be required to complete a Joint Operating Agreement (JOA) with all applicable Medicare contractors (FIs, Carriers, DME MACs, MACs, QIOs, QICs, PSCs…). The JOA shall encompass all communication between the Medicare contractor and the RAC. The JOA shall be a mutually agreed to document that is reviewed quarterly and updated as needed. The JOA shall prescribe 1) agreed upon service levels and 2) notification and escalation mechanisms with CMS involvement.

2. Referrals from CMS

   At CMS discretion, the RAC may receive referrals or “tips” on potential overpayments from CMS, ACs, and OIG or law enforcement. The RAC shall work with the appropriate entities concerning formats and transfer arrangements. The RAC must consider all referrals, but is not required to pursue all referrals.

NOTE: CMS is developing a web-based referral tracking system. This system will be available to all Medicare contractors, to CMS and to the RACs to make and track

referrals. The RACs will be required to review the referral tracking system and to determine if the referral will be reviewed or not. The RAC is not required to act upon any referral. However, the RAC is required to update CMS with the decision and status. The expected timeframe for review and decision is 30-45 days from the referral being entered into the system.

Task 3- Underpayments

The RAC will review claims, using automated or complex reviews, to identify potential Medicare underpayments. Upon identification the RAC will communicate the underpayment finding to the appropriate affiliated contractor. The mode of communication and the frequency shall be agreed upon by both the RAC and the affiliated contractor. This communication shall be separate from the overpayment communications.

After receipt the affiliated contractor will validate the Medicare underpayment. If necessary, the RAC shall share any documentation supporting the underpayment determination with the affiliated contractor. Once the affiliated contractor validates the underpayment occurrence, adjusts the claim and pays the provider, the RAC shall include the amount of the actual underpayment on the next payment invoice. Neither the RAC nor the AC may ask the provider to correct and resubmit the claim.

Once the appropriate affiliated contractor has validated the Medicare underpayment, the RAC will issue a written notice to the provider. This Underpayment Notification Letter shall include the claim(s) and beneficiary detail. A sample letter shall be approved by the CMS Project Officer before issuing the first letter.

For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group would create an underpayment, the RAC will identify an underpayment. Service lines or payment groups that a provider failed to include on a claim are **NOT** considered underpayments for the purposes of the program.

Examples of an Underpayment:

1. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy)
2. The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.

3. A diagnosis/condition was left off the MDS but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.

The following will **NOT** be considered an underpayment:

1. The medical record indicates that the provider performed additional services such as an EKG, but the provider did not bill for the service. (This provider type is paid based on a fee schedule that has a separate code and payment amount for EKG)
2. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided…however, the additional minutes do not affect the grouper or the pricier. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
3. The medical record indicates that the provider implanted a particular device for which a device APC exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Reporting of Underpayments

On a monthly basis the RAC shall submit a report to the PO listing all underpayments the RAC identified during the month. The report shall include the claim number, the provider number, the claim paid date(s), the original amount paid and the reason for the underpayment.

RAC DataWarehouse

Upon submission of the underpayment to the affiliated contractor, the RAC shall input the underpayment into the RAC Database. The RAC shall utilize the RAC DataWarehouse to learn of the payment amount to the provider for invoicing purposes unless other arrangements are made with the affiliated contractor in the JOA.

Provider Inquiries

The RAC will have no responsibility to accept case files from providers for an underpayment case review. If case files are received from providers that were not requested by the RAC, the RAC may shred the record requests. The RAC is under no obligation to respond to the provider.

Medical Record Requests

The RAC may request medical records for the sole purpose of identifying an underpayment. If required, the RAC will pay for all medical record requests, regardless of if an underpayment or overpayment is determined.

Appeal of the Underpayment Determination

The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination with the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC shall defer to the billing provider's judgment and request that the FI or carrier "undo" the underpayment. In addition, the RAC shall forward all supporting documentation, including the validation from the FI or Carrier to the CMS Project Officer or his/her delegate.

Task 4- Recoupment of Overpayments

The RAC(s) will pursue the recoupment of Medicare overpayments that are identified through Task 2. The recovery techniques utilized by the RAC shall be legally supportable. The recovery techniques shall follow the guidelines of all applicable CMS regulations and manuals as well as all federal debt collection standards. Some guidelines specific to CMS include, but are not limited to, 42 CFR, the Debt Collection Improvement Act of 1996, and the Federal Claims Collection Act, as amended. The RAC is required to follow the manual guidelines in the Medicare Financial Management Manual, Chapter 3 & 4, as well as instructions in CMS One Time Notifications and Joint Signature Memorandum unless otherwise instructed in this statement of work or specifically agreed to by the PO.

Adjustment Process

The RAC shall not attempt recoupment or forward any claim to the FI/Carrier/MAC/DME MAC or the applicable CMS Data Center for adjustment if the amount of the overpayment is less than $10.00. Claims less than $10.00 cannot be aggregated to allow for demand.

The RAC shall not forward any claim to the FI/Carrier/MAC/DME MAC or the CMS Data Center for adjustment if the amount of the underpayment is less than $1.00.

The RAC shall not forward claims to the FI/Carrier/MAC/DME MAC for adjustment if the claim is incorrectly coded but the coding error does not equate to a difference in the payment amount. For example, HCPCS code xxxxx requires a modifier for payment. Payment with the modifier is $25.50 per service. Without the modifier payment is $25.50 per service. While the claim without the modifier is incorrect, there is no overpayment or underpayment and the claim shall not be forwarded for adjustment.

Sometimes when the system adjusts the claim for the RAC identified overpayment other lines are adjusted because of system edits. CMS calls these additional lines associated findings. While the RAC did not identify these lines for adjustment, they were initiated because of the RAC adjustment.

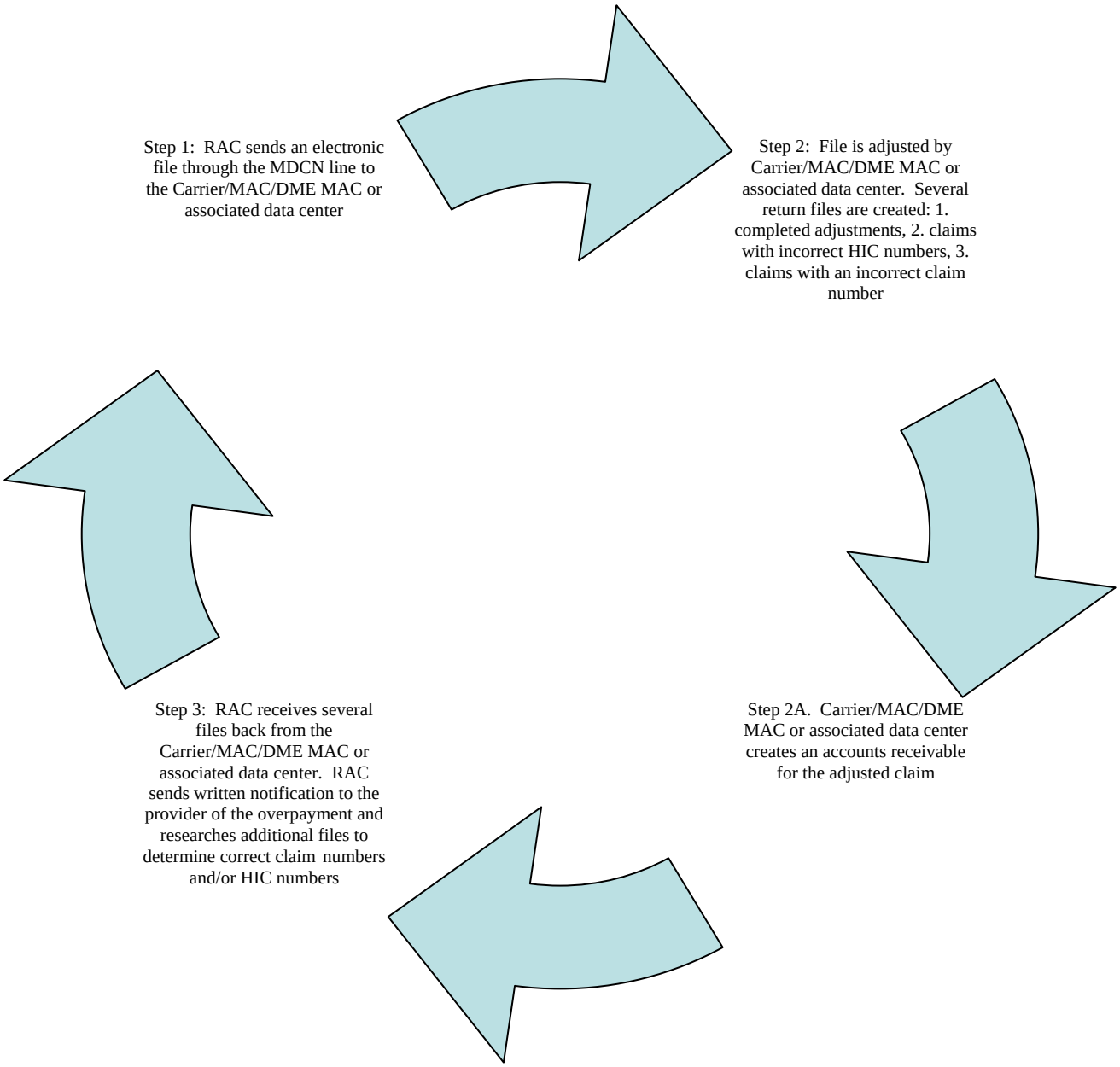
The RAC receives credit for the entire claim adjustment and the RAC shall include these additional lines and denial reason codes on the written notification to the provider. This

is currently only possible for Part B demand letters. However, RACs are still required to have knowledge and an understanding of the associated findings on all Part A claims in the event a provider has a question.

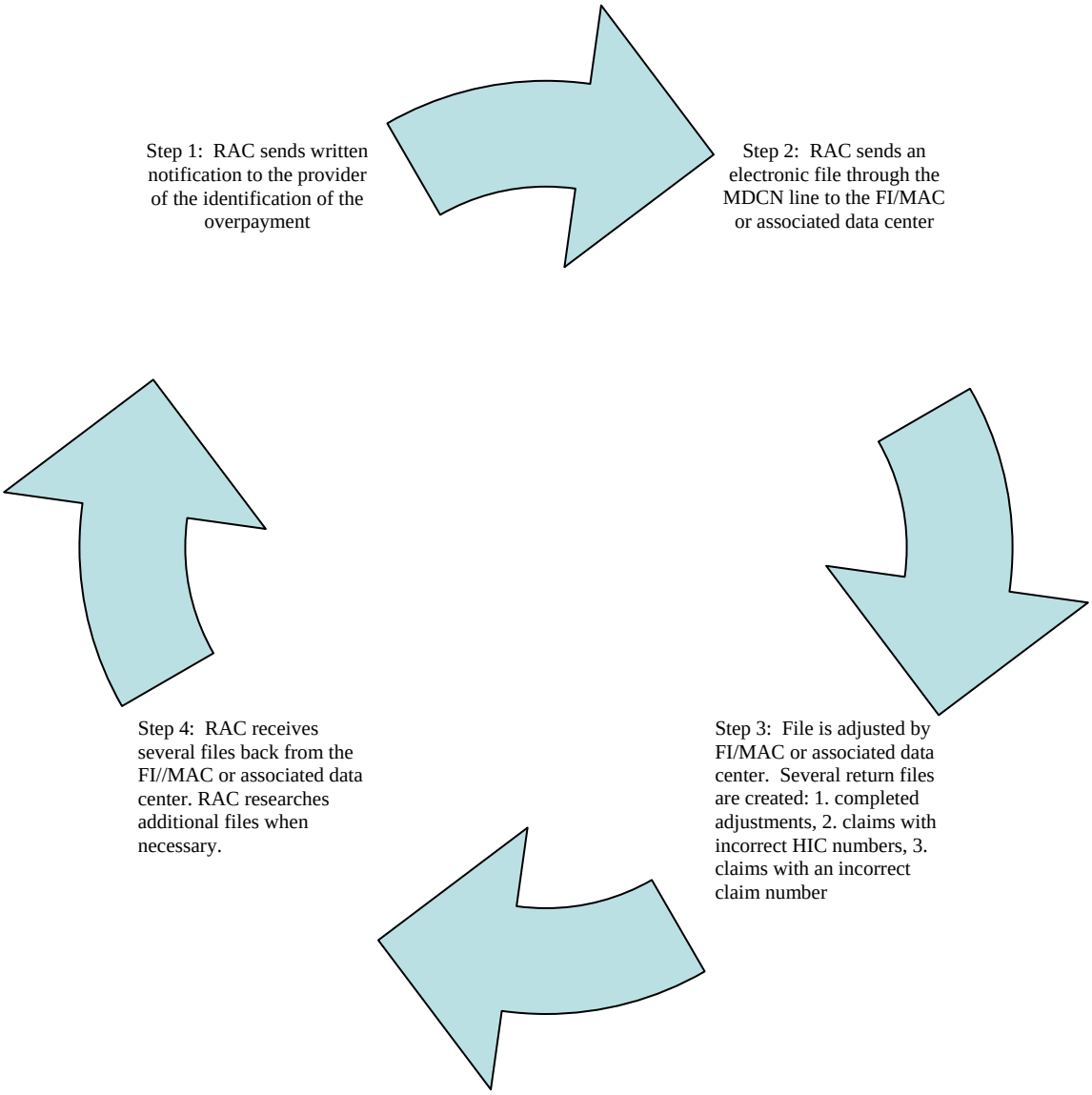
Also, a RAC identified adjustment may trigger the denial of the entire claim because of a known Medicare Secondary Payer occurrence or a known instance of the beneficiary's enrollment in a managed care plan. If an entire claim is denied because of managed care eligibility or a known MSP occurrence the RAC will not receive credit for the denial and will not receive credit for the adjustment identified by the RAC.

When partial adjustments to claims are necessary, the FI/Carrier/MAC/DME MAC shall downcode the claim whenever possible. The RAC will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount. Some examples include DRG validations where a lower-weighted DRG is assigned, claim adjustments resulting in a lower payment amount, inpatient stays that should have been billed as outpatient, SNF…. If the system cannot currently accommodate this type of downcoding/adjustments, CMS will work with the system maintainers to create the necessary changes. This includes some medical necessity claims.

Part B Adjustment Process



Part A Adjustment Process



In the demonstration each FI/Carrier/DME MAC and the RAC worked collaboratively to

develop methods to automate adjustments. This was successful in some areas and more difficult in others. In areas where automation was difficult backlogs of claims requiring adjustment were created. With expansion of the RAC Program CMS realizes the need for standardization of all reporting and automation. CMS is currently in the process of creating standard system changes to all shared systems (FISS, MCS, and VMS). CMS does not have a completion date for the system changes. Until CMS has complete system changes manual adjustments may be required and it is possible backlogs will occur. While CMS will work with the appropriate FI/Carrier/MAC/DME MAC and the RAC to eliminate the backlog, CMS will not compensate the RAC for claims stuck in the backlog.

A. Written Notification of Overpayment

Part A Process

After identification and validation, if necessary, the RAC shall send written notification of the overpayment to the provider. The written notification shall include all necessary information specified in the Medicare Financial Management Manual, Chapter 4 (unless specifically excluded in this statement of work). The CMS Project Officer shall approve all written notifications to the provider before any letters can be sent.

Part B Process

After the claim is adjusted and an accounts receivable is created, the RAC shall issue a demand letter to the provider. The demand letter shall include all necessary requirements specified in the Medicare Financial Management Manual, Chapter 4, and section 90 (unless specifically excluded in this statement of work). The CMS Project Officer shall approve all demand letters to the provider before any letters can be sent.

CMS is moving toward standardized base letters for use by each RAC. CMS anticipates the standardized base letters will be available by the award of the contract. These letters will be found in the Medicare Financial Management Manual, Chapter 4, and section 100. Use of the standardized base letter will be required; however each RAC will add additional information pertinent to each overpayment identification.

B. Recoupment through Current and/or Future Medicare Payments

Medicare utilizes recoupment, as defined in 42 CFR 405.370 to recover a large percentage of all Medicare provider overpayments. “Recoupment” as defined in 42 CFR 405.370 is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to the indebtedness. Overpayments identified and demanded by the RAC will also be subject to the existing withholding procedures. The existing withhold procedures can be found in the Medicare Financial Management Manual, Chapter 4, section 40.1.
Withholding of present and/or future payments will occur by the appropriate Medicare FI/Carrier/MAC/DME MAC. These withhold procedures will be used for all provider overpayments.

Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the RAC. All payments are first applied to interest and then to principal. Interest accrues from the date of the demand letter and in accordance with 42 CFR 405.378.

The RAC will receive a contingency payment, as stated in the Payment Methodology attachment, for all amounts recovered from withholding of present and/or future payments that are applied to the principal amount identified and demanded by the RAC.

The RAC should not stop recovery attempts strictly because recoupment of the overpayment through current and/or future Medicare payments is being attempted. Outside of the first demand letter and the Intent to Refer demand letter and the offset process, the RAC can determine the recovery methods they choose to utilize. See the Medicare Financial Management Manual, Chapter 4 §20 and §90 for minimum requirements of the Medicare FIs/Carriers/MACs/DME MACs. All recoupment methods shall be explained in detail in the bidder's proposal.

C. Repayment Through Installment Agreements

The RAC shall offer the provider the ability to repay the overpayment through an installment plan. The RAC shall have the ability to approve installment plans up to 12 months in length. If a provider requests an installment plan over 12 months in length the RAC shall forward a recommendation to the appropriate regional office. The regional office will review the case and if the recommended installment plan is over 36 months in length, the regional office will forward the recommendation to Central Office for approval. The RAC shall not deny an installment plan request. However, the RAC may recommend denial. All recommended denials shall be forwarded to the appropriate regional office for review. If necessary the regional office will request Central Office assistance. If an installment plan requires assistance from the Regional or Central Office, the package shall include all documents listed in the Medicare Financial Management Manual, Chapter 4, Section 50.3. When reviewing all installment agreements the RAC shall follow the guidelines in section 1893(f) (1) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The RAC will receive a contingency payment based on the principal amount of each installment payment. As the provider submits monthly payments, the RAC shall receive the applicable contingency payment for the principal amount received.

D. Referral to the Department of Treasury

The Debt Collection Improvement Act of 1996 (DCIA) requires federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center for cross servicing and further collection activities, including the Treasury Offset Program. CMS

is mandated to refer all eligible debt, over 180 days **delinquent**, for cross servicing.

Per DCIA referral criteria, "delinquent" is defined as debt: (1) that has not been paid (in full) or otherwise resolved by the date specified in the agency's initial written notification (i.e., the agency's first demand letter), unless other payment arrangements have been made, or (2) that at any time thereafter the debtor defaults on a repayment agreement.

Debts ineligible for referral include:

- Debts in appeal status (pending at any level);
- Debts where the debtor is in bankruptcy;
- Debts under a fraud and abuse investigation if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel, etc.) not to attempt collection;
- Debts in litigation ("litigation" means litigation which involves the federal government as a party; it does not include litigation between the debtor and some party other than the federal government);
- Debts where the only entity which received the last demand letter is the employer and the employer is a Federal agency (MSP debts only);
- Debts where the debtor is deceased;
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral (MSP debts only);
- Debts where there is a pending request for a waiver or compromise;
- Debts less than $25.00 (for non-MSP this amount is principal only; for MSP this amount is principal and interest);
- Debts of $100 or less where no TIN is available.

The RAC shall issue a written notification to the debtor with the appropriate intent to refer language within a time frame that allows for the RAC to issue an appropriate reply to all timely responses to the "intent to refer" letter before the debt is 130 days **delinquent**. All outstanding debts remaining unresolved and not under a non-delinquent installment agreement must be sent to the affiliated contractor for referral to Treasury on or before they are 130 days delinquent. The intent to refer language can be found in the Medicare Financial Management Manual, Chapter 4, and Section 70. The RAC is required to cease all recovery efforts once the debt is referred to the Department of Treasury. The AC will prepare the case for referral and will notify the RAC, through the RAC Data Warehouse when the debt is referred. Once the overpayment referred is it is no longer the responsibility of the RAC.

E. Compromise and/or Settlement of Overpayment

The RAC shall not have any authority to compromise and/or settle an identified or possible overpayment. If a debtor presents the RAC with a compromise request, the RAC shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. The RAC must include its recommendation on the request and justification for such recommendation. If the debt is greater than $100,000, the package must include a completed Claims Collection Litigation Report (CCLR). If the provider

presents the RAC with a settlement offer or a consent settlement request, the RAC shall forward the overpayment case and all applicable supporting documentation to the CMS PO for direction. If CMS determines that a compromise and/or settlement is in the best interests of Medicare, the RAC shall receive a contingency payment for the portion of principal that was recouped, providing that the RAC initiated recoupment by sending a demand letter prior to the compromise and/or settlement offer being received.

F. Voluntary/Self-Reported Overpayments by the Provider

If a provider voluntarily self-reports an overpayment after the RAC issues a demand letter or a request for medical record, the RAC will receive a discounted contingency fee based on the Payment Methodology Scale. In order to be eligible for the contingency fee, the type and dates of service for the self-reported overpayment must be in the RAC's most recently approved project plan.

- If the provider self-reports this kind of case to the RAC, the RAC shall document the case in its files and the RAC Data Warehouse, and forward the check to the appropriate Medicare contractor.

- If the provider self-reports this kind of case to the Medicare contractor, the Medicare contractor will notify the RAC. The RAC will document the case in its files and the RAC Data Warehouses. Timeframes associated with the reporting of the voluntary/self-reported overpayment shall be addressed in the JOA between the RAC and the AC/MAC.

The RAC shall cease recovery efforts for the claims involved in the self-report immediately upon becoming aware (i.e., when the RAC is notified by the Medicare contractor, the provider, etc.)

If a provider voluntarily self-reports an overpayment, and the self-reported overpayment does NOT involve the same types of services for which the RAC had issued a demand letter or a request for medical records, then the RAC is not entitled to a contingency fee amount.

- If the provider self-reports this kind of case to the RAC, the RAC shall forward the check to the appropriate Medicare contractor.

- If the provider self-reports this kind of case to the Medicare contractor, the RAC need take no action.

The RAC may continue recovery efforts since the overpayment the provider self-reported involved a different provider/service combination.

<u>Unsolicited/Voluntary Refunds (by check or claims adjustment, including those due to credit balances</u>)
Occasionally the AC may receive an unsolicited/voluntary refund from a provider. An

unsolicited/voluntary refund is a refund that is submitted to the AC without a demand letter. It is a situation where the provider realizes that a refund is due the Medicare program and refunds the money to the AC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued. The RAC shall not receive any contingency payment on an unsolicited/voluntary refund.

G. Recoupment During the Appeals Process

The RAC shall ensure that all demand letters initiated as a result of an identified overpayment in Task 2 contain provider appeal rights, where applicable.

If a provider files an appeal with the appropriate entity within the appropriate timeframes, the RAC shall follow all CMS guidance regarding Section 1893(f) (2) of the Social Security Act as amended by section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 regarding the limitation on recoupment.

If Section 935(a) is applicable following all CMS guidelines, once the RAC is notified of the appeal request, the RAC shall cease all recovery efforts. If a provider instructs the RAC that it has filed an appeal, the RAC shall cease recovery efforts and confirm the appeal request with the CMS Project Officer or its delegate. After the reconsideration level of the appeal process (completed by the Qualified Independent Contractor (QIC)) is adjudicated (or the first level of appeal if the QIC reconsideration process has not been implemented yet), the RAC shall resume recovery efforts if the decision was not favorable to the provider.

The aging of the provider overpayment for debt referral purposes will cease while recovery efforts are stopped during the appeal process. Interest shall continue to accrue, from the date of the demand letter, throughout the appeals process.

H. Interest

Regulations regarding interest assessment on determined Medicare overpayments and underpayments can be found at 42 CFR 405.378. Interest will accrue from the date of the final determination and will either be charged on the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed. The interest rate in effect on the date of final determination is the rate that will be assessed for the entire life of the overpayment. When payments are received, payments are first applied to any accrued interest and then to the remaining principal balance. Contingency fees are based upon the principal amounts recovered. All payments are applied to interest first, principal second.

I. Customer Service

The RAC shall provide a toll free customer service telephone number in all correspondence sent to Medicare providers or other prospective debtors. The customer service number shall be staffed by qualified personnel during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone. For example, if the RAC is

conducting the demonstration in California the customer service number shall be staffed from 8:00am to 4:30pm Pacific standard time. After normal business hours, a message shall indicate the normal business hours for customer service. All messages playing after normal business hours or while on hold shall be approved by the CMS Project Officer before use.

The staff answering the customer service lines shall be knowledgeable of the CMS recovery audit program. The staff shall have access to all identified improper payments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider. If need be, the staff person responsible for that overpayment shall return the call within 1 business day. The RAC shall provide a translator for Spanish speaking providers or other prospective debtors. This translator shall be available within 1 business day of the provider's original call.

The RAC shall utilize a Quality Assurance (QA) program to ensure that all customer service representatives are knowledgeable, being respectful to providers and providing timely follow-up calls when necessary. The QA program shall be described in detail in the proposal.

The RAC shall respond to written correspondence within 30 days of receipt. The RAC shall provide the CMS Project Officer with copies by fax and mailed hard copy, of all correspondence indicating displeasure with the RAC, in the overpayment identification, or in the recovery methods utilized, within ten (10) calendar days of receipt of such correspondence. (If the RAC is not sure how the correspondence will be interpreted, it should forward the correspondence to the CMS PO.)

The RAC shall provide remote call monitoring capability to CMS personnel in Baltimore or the regional offices, if directed by the CMS PO. The RAC phone system must notify all callers that the call may be monitored for quality assurance purposes.

The RAC shall retain a written report of contact for all telephone inquiries and supply it to the CMS PO within 48 hours of it being when requested.

The provider outreach plan should include a component on customer service and should be updated with the project plan, as needed. CMS may stop recovery work in a particular region if evidence leads CMS to believe the customer service plan is not appropriate and/or effective. This "stop order" would be effective until CMS was satisfied with all improvements made in the customer service area.

Task 5- Supporting Identification of Overpayments in the Medicare Appeal Process and/or in the DCIA Process.

Providers are given appeal rights for the majority of Medicare overpayments determined during the post payment review process. If a provider chooses to appeal an overpayment determined by the RAC, the RAC shall assist CMS with support of the overpayment determination throughout all levels of the appeal.

This includes providing supporting documentation (including the medical record) with appropriate reference to Medicare statutes, regulations, manuals and instructions when requested, providing assistance, and representing CMS at any hearings associated with the overpayment when requested by CMS.

Providers shall request an appeal through the appropriate Medicare appeals process. A third party shall adjudicate all appeal requests related to provider overpayments identified by the RAC. This third party may be the current Medicare contractor, a third party contractor identified by CMS, a Qualified Independent Contractor, an Administrative Law Judge, or HHS' Departmental Appeals Board's Medicare Appeals Council. Some recovery claims may eventually be appealed to the appropriate Federal court. If the RAC receives a written appeal request it shall forward it to the appropriate third party adjudicator within one business day of receipt. If the appropriate Medicare contractor is not known, the RAC shall contact the CMS PO within one business day of receipt for assistance. If the RAC receives a verbal request for appeal from a provider, the RAC shall give the provider the telephone number of the appropriate Medicare contractor and inform them that their verbal request does not suspend the permissible time frame for requesting an appeal as set forth in the demand letter.

The appropriate Medicare contractor will notify the RAC and the CMS PO of the appeal request and the outcome of each applicable appeal level. This notification will occur at least one a month.

Additionally the RAC must provide support, as needed, if the debt is disputed outside of the formal administrative appeals process after being returned to the local contractor (or a third party as designated by CMS) for further collection action including referral to the Department of the Treasury for further debt collection activities.

Task 6a- Reporting of Identified, Demanded and Collected Medicare Overpayments and Identified Medicare Underpayments

The RAC will be required on a monthly basis to provide the CMS PO or its delegate with detailed information concerning overpayments and underpayments that have been identified, overpayments that have been demanded and overpayments that have been fully or partially collected. The RAC shall have supporting documentation for all line items on the report. This report will be due no later than the fifth (5^{th}) business day of the following month. Task 1, C.2 contains additional information required in the monthly financial reports.

Data Warehouse Reporting of Possible/Identified Improper Payments

CMS utilizes a Data Warehouse to house information on potential and outstanding improper payments under the RAC realm of responsibility. This Data Warehouse stores outstanding overpayment data, determination dates, principal and interest amounts, the status of the overpayment and allows CMS to prepare detailed and/or summary reports from various data included in the Data Warehouse.

The chart below summarizes when a RAC shall enter data into the Data Warehouse.

RAC chooses claim for potential review- automated or complex	RAC inputs claim into the RAC Data Warehouse- If suppressed or excluded RAC stops work on this claim/line number If not suppressed or excluded RAC continues work
COMPLEX REVIEW or PART A automated review	
RAC requests a medical record	RAC updates a status record with a medical record request
RAC sends a demand letter or a no demand letter*	RAC updates a status record with the demand letter status, no demand letter status and the date of the demand letter
RAC receives the collection amount from the FI	RAC or FI updates a status record with the overpayment amount
	RAC or FI updates a status record with the collection amount
AUTOMATED REVIEW	
RAC sends claims to Carrier or DME MAC for adjustment	
Carrier or DME MAC inform RAC of overpayment amount	RAC or Carrier/DME MAC updates a status record with the overpayment amount
RAC issues demand letter to provider	RAC or Carrier/DME MAC updates a status record with the demand letter status, demand letter date and account receivable number
RAC receives notification from Carrier or DME MAC concerning collection	RAC or Carrier/DME MAC updates a status record with the collection amount and the collection method

* For purposes of the RAC Data Warehouse, a Part A informational letter is a demand letter

A status record should also be input upon notification of an appeal.

RAC Data Warehouse Reporting and RAC Invoices

The RAC Data Warehouse is an integral participant in the success of the RAC project. However, the RAC Data Warehouse can only be successful if the data input into it by the RAC is reliable, timely and valid. In order for a RAC voucher to be paid, all supporting information for the voucher shall be in the RAC Data Warehouse, on the RAC invoice and on the listing received from the Medicare contractor (FI, Carrier, DMAC, MAC, DME MAC) **If a claim is not listed in all three, the claim will be removed from the invoice and not paid. Repeated occurrences could lead to entire invoices not being paid.**

CMS will utilize the following reports from the RAC Data Warehouse:

Part A

1. A report of all Part A collections for the month

2. A report of all Part A adjustments and appeals for the month

3. A report of all Part A underpayments for the month

1 + 3 - 2 = invoice amount

Part B

1. A report of all Part B collections for the month where offset was used.

2. A report of all Part B collections for the month where a check was received.

3. A report of all Part B adjustments and appeals for the month.

4. A report of all Part B underpayments for the month.

1 + 2 + 4 – 3 = invoice

Once available in the RAC Data Warehouse, these reports will be available to each RAC for download. These reports will be by RAC and by contractor number. The total of all reports for the RAC jurisdiction should equal the RAC invoice. Discrepancies must be notated along with supporting documentation.

Inaccurate Information Input into the RAC Data Warehouse

CMS hires a contractor to maintain and enhance the RAC Data Warehouse. Whenever erroneous files are input into the RAC Data Warehouse, CMS has to pay the contractor by the hour to fix the file. All costs attributed to fixing errors input by the RAC will be absorbed by the RAC. CMS will accomplish this by notifying the RAC and by subtracting that amount from the next invoice.

For example: A RAC uploads a file of 30,000 claims and later realizes that the wrong provider type was input. In order to fix the error, CMS must notify the RAC Data Warehouse maintainer to change the provider type or delete the entire file. If this takes 4 hours to complete and the RAC Data Warehouse maintainer is paid $100 per hour, the next invoice for the RAC will have $400 deducted from it for the cost of the error.

CMS has instituted this new process to ensure all RACs understand the importance of the RAC Data Warehouse and take due diligence when inputting information into it and to ensure that CMS can accurately budget for the maintenance of the RAC Data Warehouse.

Task 6b Other Systems Created by RAC

The RAC is free to utilize a subsequent system in addition to RAC Data Warehouse provided by CMS. Any subsequent system shall not take the place of the RAC Data Warehouse.

All reports generated from an alternative system shall be converted to Microsoft Excel 2000 prior to submission to the CMS PO.

Task 7 – Administrative and Miscellaneous Issues

A. Administrative Functions

Once the RAC has identified an overpayment, the RAC shall send the debtor written notification as indicated in Task 4A. This notification shall request that the debtor submit payment in full. Payments shall be sent to the appropriate Medicare FI/Carrier/DME MAC/MAC.

B. Separate reporting

The reporting and data collection/analysis or each of the major tasks must be kept separate and submitted in the appropriate format per Task 1.

C. Payment Methodology

All payments shall be paid only on a contingency fee basis and shall be based on the principal amount of the collection or the amount paid back to a provider (underpayment).

Contingency fees:

- Because interest collected is returned to General Revenue rather than to the Medicare trust funds, a contingency fee shall not be paid on any interest collected.

- The RAC shall not receive any payments for the identification of the improper payments.

- The contingency fee will be determined by the overpayments collected without consideration given to the underpayments identified (i.e. without netting out the underpayments against the overpayments.) Underpayments in a claim are counted separately.

- The RAC shall receive 75% of the agreed upon contingency percentage for

recovery efforts accomplished through the offset process of a Part A claim (processed by the FISS) by a FI/MAC

- The RAC shall receive 50% of the agreed upon contingency percentage for any of the following recovery efforts:

  - ❖ Recovery efforts accomplished through the offset process by a carrier/DME MAC or a Part B claim by a MAC.

  - ❖ Recovery efforts accomplished through Treasury offset or another collection vehicle after the debt is referred to the Department of Treasury.

  - ❖ Recoveries made through a self-disclosure made by a provider in result of a prior RAC identified request for medical records or demand letter. Self-disclosed service and time period must be included in the RAC's project plan.

- If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at **ANY** level, the RAC shall repay Medicare the contingency payment for that recovery. Repayment to Medicare will occur on the next applicable invoice.

D. Point of Contact for RAC

The primary point of contact for the RACs shall be the CMS PO or his/her delegate.

E. Data Accessibility

CMS shall provide the RAC with all applicable data files for all claims paid during the specific timeframes of the contract for the appropriate geographic area. The RAC will receive new data updates as they become available. (monthly or quarterly) The data file format, data fields available and user agreements can be found at http://www.cms.hhs.gov/AccesstoDataApplication/www.cms.hhs.gov.

To access data the RAC shall acquire a Medicare Direct Connect Network (MDCN) line. This is a secure line between the RAC and the CMS Data Center. The cost of the MDCN line shall be incurred by the RAC. Anticipated costs range from $1500-$2000 per month. This does not include setup costs. These costs may increase at any time. CMS will provide the applicable points of contact to set up the MDCN line. In addition, the RAC must acquire the appropriate software to enter into the CMS Data Center. Stellant Direct: Connect software is currently being utilized by CMS for this purpose. There is no other alternative software. At this time the price of the Stellant Direct: Connect software is approximately $185,000.00. The RACs are responsible for all costs of the MDCN line and the Stellant Direct: Connect software.

As CMS moves towards utilizing Enterprise Data Centers (EDC) the transmission of data may cease. The RAC may be required to utilize a CMS system in a CMS Data Center to

retrieve extracts of claims.

The RAC shall pay for any charges associated with the transfer of data. This includes, but is not limited to, cartridges, data communications equipment, lines, messenger service, mail, etc. The RAC shall pay for all charges associated with the storage and processing of any data necessary to accomplish the demonstration. The RAC shall establish and maintain back-up and recovery procedures to meet industry standards. The RAC shall comply with all CMS privacy and security requirements. The RAC shall provide all personal computers, printers and equipment to accomplish the demonstration throughout the contract term.

F. Recalled Cases

CMS may determine that a case or a particular uncollectible debt should be handled by CMS staff and may recall the case/debt for that reason. Should CMS recall a case/debt, the RAC shall immediately stop all activities on the case/debt identified by CMS for recall and return the case/debt and all related information to CMS within one (1) business day of the recall request.

The RAC shall receive no payment, except for monies already recouped, for recalled cases.

A BI PSC or BI Unit of a DME MAC may determine that overpayment identification or recoupment action on a case, provider, and geographic region should cease and may recall the case for that reason. Should the BI PSC/unit recall a case, provider, geographic region, the RAC shall immediately stop all activities on the case identified by the BI PSC/unit for recall. The RAC shall receive no payment, except for monies already recouped for recalled cases.
All requests for recall shall be forwarded to the CMS PO for concurrence. CMS and the BI PSC or BI Unit of a DME MAC shall have a valid reason for the recall of the case. If there is a dispute, the CMS PO shall make the final decision concerning the recall of the case.

G. Case Record Maintenance

The RAC shall maintain a case file for every improper payment that is identified, including documentation of subsequent recovery efforts. This file shall include documentation of all processes followed by the contractor including a copy of all correspondence, including demand letters, a telephone log for all conversations with the provider or other individuals or on behalf of the provider or other debtor, and all collection activities (including certified/registered mail receipts, extended repayment agreements, etc). The case file may be electronic, paper or a combination of both. For electronic files, the case file shall be easily accessible and made available within 48 hours of request. At CMS's request or no later than fifteen (15) days after contract termination, the RAC shall return to CMS all case files stored in accordance with CMS instructions. Once an improper payment is determined all documentation shall be kept in the case file. The RAC shall not destroy any supporting documentation relating to the identification or

recovery process.

All case files shall meet the requirements as set by OMB Circular A-130, which can be found at http://www.whitehouse.gov/omb/circulars/a130/a130trans4.html.

H. Recovery Deposits

The demand letters issued by the RAC will instruct debtors to forward their refund checks to the appropriate address at the applicable Medicare contractor (FI/Carrier/DME MAC/MAC). All refund checks shall be payable to the Medicare program. If the RAC receives a refund check, the RAC shall forward the check to the appropriate address. Before forwarding the check, the RAC shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

I. Support OIG or Other Audits

Should the OIG, CMS or a CMS authorized contractor choose to conduct an audit of the RAC, the RAC shall provide workspace and produce all needed reports and case files within 1 business day of the request.

J. Support Evaluation Contractor

CMS is required to report on the RAC Program annually. To assist with the report, CMS utilizes an independent evaluation contractor. This contractor assists CMS with the analysis of data, completes the provider survey, may assist CMS in monitoring the RACs, and maintains the referral database. Each RAC will have a point of contact for the Evaluation Contractor and each RAC shall assign a point of contact in their organization. At times, the evaluation contractor may request data from each RAC. All requests will be filtered through the CMS PO and should be addressed within 15 days of receipt unless otherwise noted in the request.

K. Public Relations & Outreach

The initial project plan shall include a section covering provider outreach. CMS will announce the use of the RACs in the specified geographic area. All other debtor education and outreach concerning the use of RACs will be the responsibility of the RAC. The RAC shall only educate providers on their business, their purpose and their process. The RACs shall **not** educate providers on Medicare policy. The CMS PO shall approve all presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use. If requested by CMS, the RACs project manager for the CMS contract, at a minimum, shall attend any provider group or debtor group meetings or congressional staff information sessions where the services provided by the recovery audit contractors are the focus.

The RAC is required by January 01, 2010 to develop and maintain a Medicare RAC webpage to communicate to the provider community helpful information (e.g., who to

call for an extension, how to customize the address for a medical record request letter). The Medicare information shall appear on pages that are separate and distinct from any other non-Medicare work the RAC may have. The RAC shall obtain prior PO approval for all Medicare webpage content.

L. Quality Assurance

1. Each RAC shall be required to complete a Statement of Auditing Standards No. 70 (SAS 70) Audit. Each RAC shall be responsible for contracting with an independent and certified public accounting (CPA) firm to perform the audit. The CPA firm will ideally have experience in Medicare operations and must have experience performing SAS 70 Type II audits.

CMS control objectives can be found in IOM Pub. 100-6, Chapter 7. CMS will dictate which control objectives will be applicable to the audit. The scope of the audits will be dictated by CMS and will be determined no later than 180 days after award. A final report from the CPA firm must be submitted to CMS by the end of each award year. Any corrective action plan must be submitted to CMS within 45 days of the issuance of the final report.

Additional general information concerning a SAS 70 audit can be found in IOM Pub. 100-6, Chapter 7.

2. At CMS discretion, CMS may perform a contractor performance evaluation. Advance notice may/may not be given. During the evaluation CMS reviewers will work from a prescribed audit protocol, review actual cases and issue a final report. Any finding from the review will require a corrective action plan.

3. At CMS discretion, CMS may contract with an independent contractor to perform an accuracy audit on a RAC's identifications. At a minimum, this audit would be performed annually.

Task 8 Final Report

The final report shall include a synopsis of the entire contract project. This includes a final report identifying all amounts identified and demanded, all amounts collected and all amounts still outstanding at the end of the demonstration. It shall include a brief listing of all identification methods or other new processes utilized and their success or failure.
The contractor should include any final thoughts on the program, as well as any advantages or disadvantages encountered. From a contractor point of view, the final report should determine if the contract was a success or a failure and provide support for either opinion.

A final report shall be delivered to the CMS PO in the three formats (paper/electronic) as stated below and in the required "electronic" formats to the *fnlrpts@cms.hhs.gov* mailbox:

1) Paper, bound, in the number of copies specified;
2) Paper, unbound, suitable for use as camera-ready copy;
3) Electronic, as one file in Portable Document Format (PDF), as one file in Hypertext 200-word abstract/summary of the final report suitable for submission to the National Technical Information Service. Drafts of all documentation shall be provided to CMS approximately four weeks prior to final deliverable due dates unless otherwise agreed to. CMS staff will review materials and provide comments back to the contractor within 2 weeks, thereby allowing 2 additional weeks for the contractor to make any necessary revisions. All data files and programs created under this project shall be the sole property of CMS and provided to CMS upon request in the appropriate format. They shall not be used for any other purpose other than fulfilling the terms of this contract without the express permission of the contracting officer.

SCHEDULE OF DELIVERABLES

The contract awarder shall provide the necessary personnel, materials, equipment, support, and supplies to accomplish the tasks shown below in the specified time. The contract awarder shall complete the evaluation and report to CMS its findings. All work done under this contract shall be performed under the general guidance of the CMS PO subject to the PO's approval.

Written documents for this project shall be delivered in hard copy to the project officer (2 copies), unless otherwise specified. These documents shall also be delivered to the Project Officer in an electronic version via email. At present, the CMS standard is Microsoft Word 2000 and Microsoft Excel 2000. This is subject to change, and the contractor shall be prepared to submit deliverables in any new CMS standard.

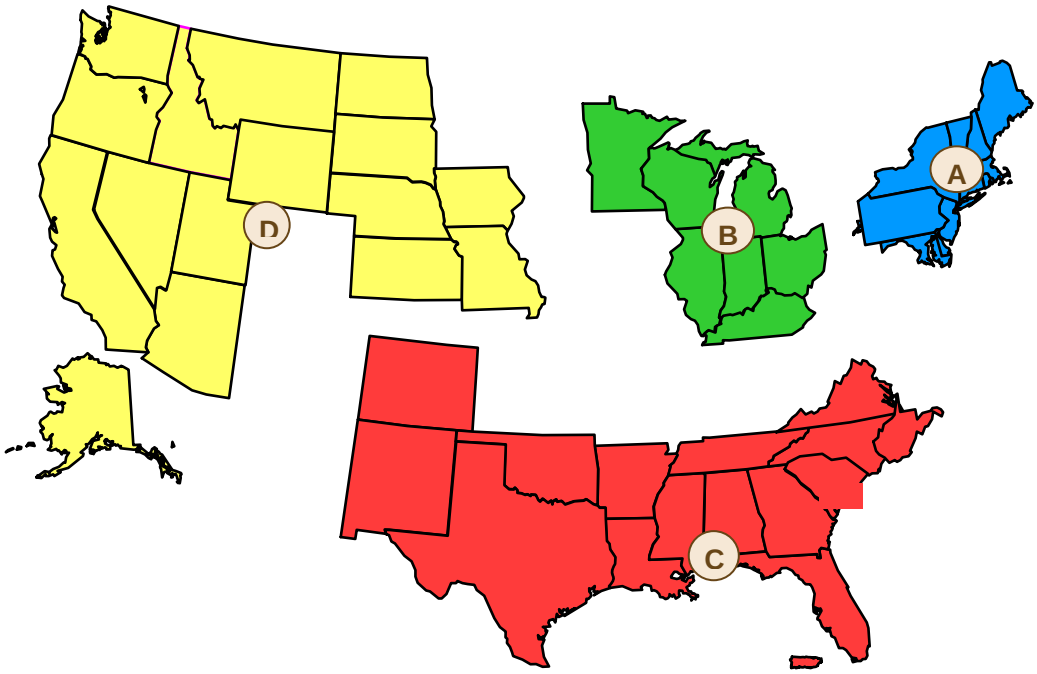
Task Number	Deliverable Number	Deliverable	Due Date (from contract award date)
1.a.	1	Initial Meeting	2 weeks
1.a.	2	Project Plan	4 weeks
1.b.	3	Monthly Conference Calls	Monthly
1.c.	4	Monthly Progress Reports	Monthly
6	5	Financial Report	Monthly
1	6	Vulnerability Report	Monthly
6	7	Training on RAC Data Warehouse	Within 15 days of the start of Task 2
6	8	Case File Transfers	Within 15 days after contract end
9	9	Final Report- Draft	Within 4 weeks of contract end date
9	10	Final Report- Final	Within 8 weeks of contract end date

PAYMENT METHODOLOGY SCALE

1	% When recovery is made through RACs efforts (check sent in by provider in response to demand letters, phone calls…)	_____
2	75% of the contingency fee specified in number 1 above when recovery is made through the offset process by the Medicare fiscal intermediary or MAC (Part A claims only)	
3	50% of the contingency fee specified in number 1 above when recovery is made through the offset process by the Medicare **carrier/DME MAC/MAC** (Part B claims).	
4	50% of the contingency fee specified in number 1 above when recovery is made after the debt is referred to the Department of Treasury	
5	50% of the contingency fee specified in number 1 when a self-disclosure is made by a provider in result of a prior RAC identified request for medical requests or demand letter/ Self disclosed service and time period must be included in the RAC's project plan	
6	100% of the contingency fee specified in number 1 when an underpayment is identified as a result of automated or complex review. Payment occurs after the FI/Carrier/DME MAC/MAC validates the underpayment and determines the actual amount	
7	% When no recovery is made for an overpayment	0%

Appendix 1- Intentionally Left Blank

Appendix 2: Map of Recovery Audit Contract Regions



Transition of Inpatient Hospital Review Workload

*An Overview of Changes to the Review of Acute Inpatient Prospective Payment System (IPPS) Hospital and Long Term Care Hospital (LTCH) Claims**

Office of Financial Management
Program Integrity Group

Date: June 2008

** Also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver*

Outline

- The Old Environment
- The New Environment
- Roles under the New Environment
- Why the Change?
- When will the Transition occur?
- What will be Different?
- What will be the Same?

Acute IPPS Hospital and LTCH Claim Review: The Old Environment

- In the past, **QIO**[1] responsibility included:
  - Hospital Payment Monitoring Program (HPMP) reviews
    - Conducting utilization reviews for payment purposes
    - Measurement of the accuracy of Medicare FFS payments for short- and long-term acute care hospitals
  - Quality of care reviews to ensure that care provided to Medicare beneficiaries meets professionally recognized standards of healthcare
  - Performance of provider-requested higher-weighted DRG reviews
  - Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases
  - Performance of Expedited Determinations
- Medicare Part A claims processing contractors, called **FIs**[2] **and MACs**[3] had no acute care inpatient hospital claim review responsibility
- **CERT**[4] program had no acute care inpatient hospital claims improper payment measurement responsibility

1 – Quality Improvement Organizations
2 – Fiscal Intermediaries
3 – Medicare Administrative Contractors
4 – Comprehensive Error Rate Testing

Acute IPPS Hospital and LTCH Claim Review: The New Environment

- **QIOs** will focus their efforts on quality improvement and continue to perform quality reviews, certain utilization reviews, such as, provider-requested higher-weighted DRG and EMTALA reviews, and expedited determinations.[5]
- **FIs and MACs** will perform most utilization reviews of acute care inpatient hospital claims
- **CERT** will measure the inpatient hospital paid claims error rate

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5 – The QIO 9th Statement of Work provides a full listing of activities and is available at http://www.cms.hhs.gov/QualityIMprovementOrgs/04_9thsow.asp

Acute IPPS Hospital and LTCH Claim Review: Why the Change?

CMS initiated the change in response to recommendations by OIG[6] and the Institute of Medicine[7]

There are 3 primary benefits to the transition:

- Consistency
  - Acute long- and short-term hospitals have been the only Medicare Fee For Service (FFS) settings not reviewed by FIs and MACs
  - These hospitals have been the only settings not included in the CERT error rate measurement
- Efficiency
  - The entities that process claims will be responsible for preventing improper payments
  - We anticipate the new strategy will be more cost effective since fewer contractors will be conducting the non-quality reviews
- Mitigation of the Perception of a Potential Conflict of Interest

  There is the perception of a potential conflict of interest created by having the QIOs measure the payment error rate for claims on which they themselves made payment determinations.

The transition will enable QIOs to focus efforts on quality improvement and maintenance.

6 – Office of Inspector General Report: Oversight and Evaluation of the Fiscal Year 2005 Comprehensive Error Rate Testing Program (A-03-05-00006) (http://oig.hhs.gov/oas/reports/region3/30500006.pdf)
7 – Institute of Medicine Report: Medicare's Quality Improvement Organization Program, Maximizing Potential (http://www.iom.edu/CMS/3809/19805/33411.aspx)

Acute Care Inpatient Hospital Claim Review: When will the transition occur?

- **CERT** began reviewing acute care hospital claims for **improper payment measurement** in April 2008
  - This corresponds with the beginning of the November 2009 Medicare FFS Improper payment report period.
  - CERT will review claims submitted April 1, 2008 forward
- We anticipate **FIs and MACs** will begin performing reviews on acute care inpatient hospital claims for **improper payment prevention/reduction** in the Summer 2008
  - FIs and MACs would be allowed to review claims submitted January 1, 2008 forward.

Acute IPPS Hospital and LTCH Claim Review: How will reviews be different?

Because of varying statutory requirements, the FI/MAC, CERT, and QIO review procedures differ. The review procedures for acute inpatient hospital claims will be consistent with the procedures used by FIs/MACs and CERT for review of outpatient hospital claims and all other Medicare FFS claims.

Claim Selection

- After the first phase of review, FIs/MACs will perform targeted medical review, based on data analysis, not random review like QIOs have done.
  - During the first phase, FIs/MACs will have the option to perform targeted or random medical review.
- FIs/MACs can perform medical review on a prepayment OR postpayment basis, unlike QIOs who only performed postpayment review
- CERT performs random reviews and utilizes different sampling, review, and calculation methodologies than those used by the QIOs to establish and report an error rate. Because of the difference in approach, CERT error rates will not be comparable to previous QIO-calculated error rates.

Acute IPPS Hospital and LTCH Claim Review: How will reviews be different? (cont)

- **Medical Record Requests**
  - The CERT Documentation Contractor will notify providers that claims have been selected for CERT review via letter or telephone contact.
    - The medical record request letter will be mailed or faxed according to the hospital's preference
    - Hospitals may submit medical records via mail or fax. The CERT Documentation Contractor also accepts CDs with imaged medical records.
  - The FIs and MACs will send an automated letter or provide instructions for how to access FISS (the claims processing system) for Additional Documentation Requests (ADRs). Providers may use the claim inquiry screen in Direct Data Entry (DDE) to verify the status of claims suspended for medical review, as they currently do for outpatient claims and other types of claims.
    - Hospitals submit hardcopy medical records via mail

Acute IPPS Hospital and LTCH Claim Review: How will Reviews be Different? (cont)

- **Physician Involvement in Reviews**
  - As with any claim reviewed by FIs/MACs or CERT, physicians will be utilized in acute inpatient hospital claim review to the extent that it is necessary. Qualified clinicians, such as nurses and therapists, will perform the reviews, consulting with physicians or other specialists as needed.
- **Reimbursement for Photocopy Costs**
  - Neither CERT nor the FIs/MACs reimburse for photocopying expenses for medical record requested from *any* setting.
- **Appeals**
  - Appeals of claim denials will occur *after* the payment denial is issued. Like all other Medicare claims, providers and beneficiaries will have appeal rights.

Acute IPPS Hospital and LTCH Claim Review: What will Remain the Same?

- **Review Criteria**
  - The coverage and payment guidelines used by FIs/MACs and CERT will be the same as used in the past by QIOs.
  - Like the QIOs, FIs/MACs will adhere to CMS national policy and contractor local coverage determinations (LCDs) in making payment decisions.
  - FI/MAC reviewers will utilize clinical judgment in making payment determinations, as the QIOs did.

- **Use of Screening Tool**
  - We anticipate that FIs/MACs and the CERT contractor will continue to use a screening tool for claims review, before making a determination on an individual claim basis. Like QIOs, FIs/MACs will not be required to use a specific tool.

Acute IPPS Hospital and LTCH Claim Review: Comparison At a Glance

Issue	QIOs - HPMP	CERT	FIs/MACs
Review Selection	Random	Random	Targeted
Timing of Review	Post payment	Post payment	Post payment or Pre payment
Level of physician involvement in review process	Review all claims where nonphysician reviewer identifies a problem with the claim	As needed for complex cases	As needed for complex cases
Use of coding experts	Mandatory	Mandatory	Mandatory
Reimbursement for photocopying medical records	Yes	No	No
Where to file initial appeal	QIO	FI/MAC	FI/MAC

Acute IPPS Hospital and LTCH Claim Review: Roles of Review Entities in the New Environment

Entity	QIOs	FIs / MACs	CERT	RACs	PSCs / Z PICs	PERM
Primary Review Responsibility	Promote Quality of Care	Prevent / reduce improper **Medicare FFS** payments	Measure **Medicare FFS** improper payments	Identify past **Medicare FFS** improper payments	Identify fraud and abuse in **Medicare FFS**	Measure **Medicaid** improper payments
Provider Education Responsibility	Educate about quality of care	Educate about submitting claims for correctly coded, medically necessary services	N/A	N/A	N/A	N/A

Information About the CERT Program and FI/MAC Review Process

- CERT Fact Sheet:
  www.cms.hhs.gov/MLNProducts/downloads/certfactsheetv1-3.pdf
- Medicare FFS Improper Payment reports:
  www.cms.hhs.gov/CERT
- CERT Documentation Contractor website:
  www.certprovider.org
- Medical Review Fact Sheet (being revised):
  www.cms.hhs.gov/MedicalReviewProcess/Downloads/mrfactsheet.pdf
- Program Integrity Manual – Publication 100-08:
  http://www.cms.hhs.gov/Manuals/IOM/list.asp

Questions?

THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM:

An Evaluation of the 3-Year Demonstration

June 2008

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Executive Summary

Background

Medicare is a multifaceted program. The Medicare Fee-for-Service (FFS) program consists of a number of payment systems, with a network of contractors that process over 1.2 billion claims each year, submitted by more than 1 million health care providers such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment (DME) suppliers. These contractors, called "Medicare claims processing contractors," process claims, make payments to health care providers in accordance with Medicare regulations, and are responsible for educating providers about how to submit accurately coded claims that meet Medicare's medical necessity guidelines. Despite actions to prevent or recoup improper payments, it is impractical to prevent all improper payments. A January 2008 report by the Office of Management and Budget (OMB) indicated that Medicare is among the top three Federal programs with improper payments, totaling an estimated $10.8 billion in 2007.

Improper payments on claims can occur for the following reasons:

- Payments are made for services that do not meet Medicare's medical necessity criteria.
- Payments are made for services that are incorrectly coded.
- Providers fail to submit documentation when requested, or fail to submit enough documentation to support the claim.
- Other reasons, such as basing claim payments on outdated fee schedules, or the provider is paid twice because duplicate claims were submitted.

Medicare Secondary Payer (MSP) improper payments can occur when Medicare pays a claim that should have been paid by a different health insurance company.

The RAC Demonstration

The purpose of this report is to evaluate the RAC demonstration and to share with all interested parties information about the demonstration. Congress authorized the RAC demonstration for the purpose of identifying underpayments and overpayments and recouping overpayments under part A or B of the Medicare program. Under this authority, Congress provided for payments to the RACs on a contingent basis for detecting and correcting overpayments and underpayments. Correcting includes both collecting overpayments from providers and refundung underpayments to providers.

A full and open competition was held to competitively select three Claim RACs and two Medicare Secondary Payer (MSP) RACs for the demonstration. Initially each Claim RAC was given a single State jurisdiction. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization. Each jurisdiction was expanded by one State in the summer of 2007 to include Massachusetts, South Carolina, and Arizona.

Claim RACs use a review process similar to that of Medicare claims processing contractors. Automated reviews occur when the RACs have identified improper payments because the provider clearly billed in violation of Medicare policy. For complex reviews, the RACs have identified a likely improper payment and request the medical records from the provider to conduct a more in-depth review.

The Centers for Medicare & Medicaid Services (CMS) initially provided the Claim RACs with four years of claims data for their jurisdictions. Subsequently, the Claim RACs received an additional three months of claims on a quarterly basis.

The RAC data warehouse has facilitated CMS oversight of the RAC demonstration. CMS developed

the RAC data warehouse to automate means of administering and overseeing the Claim RAC component of the demonstration.

Results of the RAC Demonstration

As of March 27, 2008, RACs succeeded in correcting more than $1.03 billion in Medicare improper payments. Approximately 96 percent ($992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent ($37.8 million) were underpayments repaid to providers. The MSP RACs collected fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million).

During a similar time period, the Medicare claims processing contractors in New York, Florida, and California corrected far fewer improper payments ($13 million in overpayments and less than $0.1 million in underpayments) but *prevented* a significant amount of improper payments by denying $1.8 billion in claims prior to payment.

Claim RAC efforts to correct improper payments grew over time. Of the total $1.03 billion in improper payments corrected by the Claim RACs from the inception of the demonstration through March 27, 2008, approximately 4 percent occurred in FY 2006, 34 percent in FY 2007, and 62 percent in the first half of FY 2008.

The majority of Medicare claims were unaffected by the Claim RACs. Of a total $317 billion in Medicare claim payments available for review by the Claim RACs through March 27, 2008, the Claim RACs identified and corrected improper payments on only 0.3 percent ($1.03 billion) of the claims received.

As of March 27, 2008, providers had chosen to appeal 14.0 percent of the RAC determinations. Of all the RAC overpayment determinations, only 4.6 percent were overturned on appeal.

Even after subtracting the dollars in refunded underpayments, overpayments overturned on appeal, and RAC demonstration operating costs, the RACs still returned millions to the Medicare Trust Funds. Through March 27, 2008, the RACs had returned $693.6 million to the Medicare Trust Funds. This number includes appeals overturned through March 27, 2008. However, it is important to note that because CMS currently is unable to track all pending first-level appeals of RAC determinations, the dollar amounts returned to the Trust Funds are subject to change. Providers have 120 days to appeal from the date of the claim adjustment, and CMS anticipates that most first-level appeals of RAC determinations will have been filed by July 1, 2008. The Medicare appeal process is described in more detail in Chapter 4.

Most overpayments (85 percent) were collected from inpatient hospital providers, 6 percent from inpatient rehabilitation facilities (IRFs), and 4 percent from outpatient hospital providers. Most overpayments occur when providers submit claims that do not comply with Medicare's coding or medical necessity policies.

Future improper payments can be avoided by analyzing the Claim RACs' service-specific findings. CMS can use this information to implement more provider education and outreach activities or establishing new system edits, with the goal of preventing future improper payments. Hospitals and other health care providers can use the information to help ensure that they are submitting correctly coded claims for services that meet Medicare's coding and medical necessity policies.

In order to determine providers' satisfaction with the RAC demonstration, CMS tasked the Gallup Organization to conduct telephone interviews with a selected sample of 589 providers between May 2007 and July 2007. The sample was selected randomly from more than 4,200 providers who had received a medical record request or an overpayment recoupment from a RAC at least once in the 12 months before the survey date. The survey asked providers questions such as whether they felt CMS's efforts to recoup overpayments are fair and reasonable, and whether they think the RACs will help ensure more accurate billing practices in the future. The survey results showed that 74 percent of the respondents found CMS's efforts to recoup overpayments to be fair and reasonable. Seventy-one percent thought that RAC reviews correctly applied Medicare policies.

The RAC demonstration had limited financial impact on most providers. Most did not receive any overpayment request letters from a RAC, and of those providers who were asked to repay an overpayment, those repayments were small in comparison with the providers' overall income from Medicare.

From its inception through March 27, 2008, the RAC demonstration cost only 20 cents for each dollar collected. RAC contingency fees were $187.2 million over the life of the demonstration. Medicare claims processing contractors' costs were $8.7 million, and other expenses were $5.4 million.

Independent Verification of Demonstration Results

Several independent organizations beyond the RACs have supported CMS in the evaluation of the RAC demonstration. To ensure the validity of data underlying the demonstration, CMS tasked Econometrica, Inc., with assessing the completeness of certain data entered in the RAC data warehouse. Econometrica also supported CMS by verifying certain summary data included in this report and documenting the results of that effort. As noted earlier, the Gallup Organization conducted an independent survey of providers to determine their level of satisfaction with the RAC demonstration. In addition, the Claim RAC Validation Contractor, AdvanceMed, provided external validation and helped ensure the accuracy of the RAC claim determinations by conducting independent, third-party reviews of improper payments.

Lessons Learned

As a result of the RAC demonstration, many of the key questions about the feasibility and merits of applying recovery audit principles and methods to the Medicare program have been answered. Namely, the demonstration has shown the following:

- Claim RACs are able to find a large volume of improper payments.
- Providers do not appeal every overpayment determination.
- Overpayments collected were significantly greater than program costs.
- Claim RACs are willing to spend time on provider outreach activities, developing strong relationships with provider organizations.
- It is administratively possible to have a RAC work closely with a Medicare claims processing contractor.
- RAC efforts did not disrupt Medicare or law enforcement anti-fraud activities.
- It is possible to find companies willing to work on a contingency fee basis.

One of CMS's goals during the RAC demonstration was to address all concerns raised by a RAC, a provider, or any other interested party, while identifying successes and opportunities for improvement before the program is expanded nationally. A number of changes were made to improve the RAC permanent program, most notably:

- Having all new issues a RAC wishes to pursue for overpayments validated by CMS or an independent RAC Validation Contractor and to share the upcoming new issues with provider organizations
- Requiring each new RAC to hire a physician medical director as well as certified coders
- Requiring the RACs to pay back contingency fees when an improper payment determination is overturned at any level of appeal
- Changing from a 4-year look-back period to a 3-year look-back period
- Adding a maximum look-back date of October 1, 2007
- Adding a Web-based application that will allow providers to look up the status of medical record reviews.

CMS is confident that these changes will help contribute to an even more successful RAC permanent program.

Implementation of the RAC Permanent Program

CMS plans to implement the RAC permanent program gradually, beginning with a limited number of States in the summer of 2008. The statute requires

that the RAC program be nationwide by January 10, 2010.

CMS and the permanent RACs will undertake aggressive outreach to providers in every State before overpayment notices and medical record requests are issued.

Conclusion

The RAC demonstration was an important tool in helping CMS prepare for and shape the RAC permanent program. This preparation led to the incorporation of several important components of the RAC permanent program, including building cooperative relationships with Medicare claims processing contractors, fraud fighters, the Department of Justice, and appeals entities; contracting with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations; limiting the claim review look-back period to three years; requiring each RAC to hire a medical director; and conducting significant outreach to providers. CMS will expand the RAC program gradually.

A Note on This Report

This evaluation report will be updated by CMS to reflect updated appeals and other statistics on a monthly basis through the summer of 2008.

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to complete a demonstration project to determine whether recovery audit contractors (RACs) could be utilized efficiently and effectively in Medicare when tasked with identifying Medicare overpayments and underpayments and recouping overpayments. It also mandated a Report to Congress 6 months after the end of the demonstration on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

In December 2006, in the Tax Relief and Health Care Act of 2006 (TRHCA), Congress authorized the expansion of RACs nationwide by January 2010. Because the question of expansion was addressed even before the end of the demonstration, the need for the Report to Congress to include recommendations to expand the program was negated. Congress realized this in TRHCA and modified the language regarding the Report to Congress to require an annual report that includes information on the performance of the contractors and an evaluation of the comparative performance of such contractors. Thus, this evaluation bridges a gap between a fully independent evaluation of the demonstration (had TRHCA provisions not been enacted) and a standard report on program performance.

At the beginning of the RAC demonstration, CMS tasked several additional contractors with helping to verify and validate the RAC results. The work of these independent entities has been included in this report.

Acronyms Used in This Report

ALJ: Administrative Law Judge

CAFM: Contractor Accounting Financial Management System

CMD: Contractor Medical Director

CMS: Centers for Medicare & Medicaid Services

Connolly: Connolly Consulting (the New York and Massachusetts Claim RAC)

CPT: Current Procedural Terminology

DCS: Diversified Collections Services (the California MSP RAC)

DHHS: Department of Health and Human Services

DME: Durable Medical Equipment

DOJ: U.S. Department of Justice

DRG: Diagnosis Related Group

ERRP: Error Rate Reduction Plan

FFS: Fee-for-Service

HCFA: Health Care Financing Administration

HCPCS: Healthcare Common Procedure Coding System

HDI: HealthDataInsights (the Florida and South Carolina Claim RAC)

IRF: Inpatient Rehabilitation Facility

LCD: Local Coverage Determination

MAC: Medicare Administrative Contractor

MMA: Medicare Prescription Drug, Improvement, and Modernization Act of 2003

MSP: Medicare Secondary Payer

NCD: National Coverage Determination

NDNH: National Database of New Hires

OIG: Office of Inspector General

OMB: Office of Management and Budget

PRG: PRG-Schultz (the California and Arizona Claim RAC)

PSC: Program Safeguard Contractor

QIC: Qualified Independent Contractor

QIO: Quality Improvement Organization

RAC: Recovery Audit Contractor

RFP: Request for Proposals

RVC: RAC Validation Contractor

SNF: Skilled Nursing Facility

TRHCA: Tax Relief and Health Care Act of 2006

VDSA: Voluntary Data Sharing Agreements

1. Introduction

This report presents an evaluation of the Medicare RAC demonstration from its inception in 2005 through March 27, 2008. More detailed data are available in the FY 2006 RAC Status Document and the FY 2007 RAC Status Document, available on www.cms.hhs.gov/RAC. CMS will release updates to this RAC Evaluation Report on a regular basis at least through the summer of 2008. The update reports will contain updated appeals and other statistics.

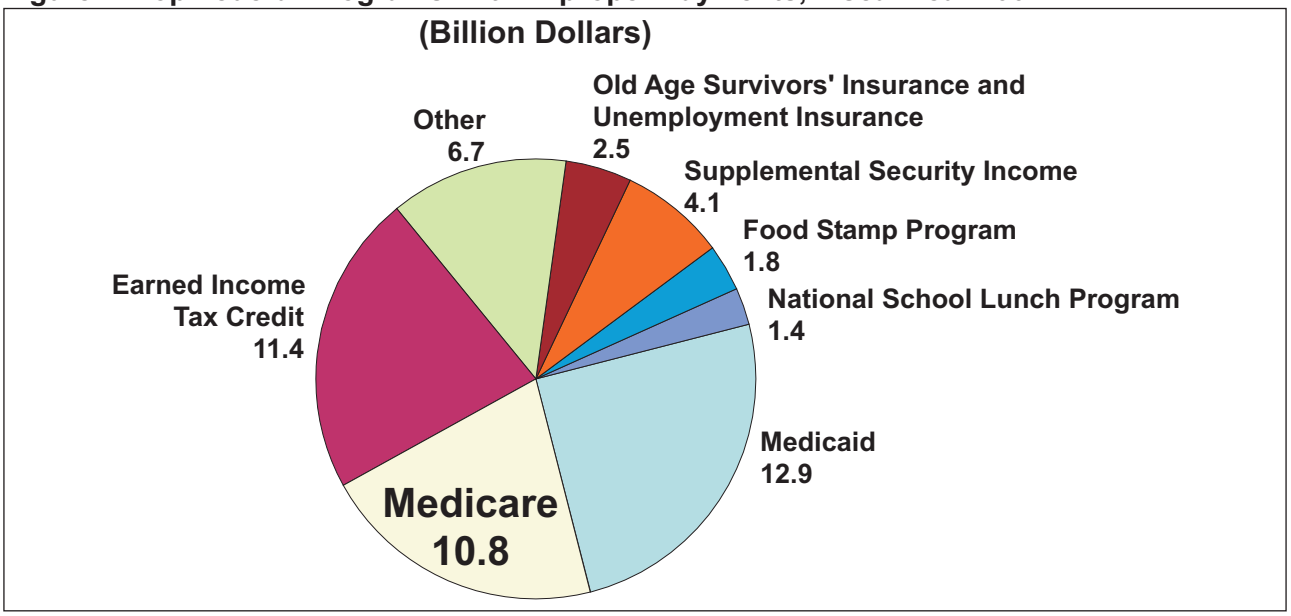
Overview of Concerns With Improper Payments in Medicare

According to a January 2008 report by the OMB, Medicare—with an estimated $10.8 billion in improper payments in 2007—is one of the top three Federal programs with improper payments (see Figure 1).

With increasing expenditures, expanding Federal benefits, and a growing beneficiary population, the importance and the challenges of safeguarding the Medicare program are greater than ever. CMS, the Federal agency that operates the Medicare program, has a relatively long history of calculating improper payment estimates and developing strategies to protect the Medicare program's fiscal integrity. In 2003, CMS implemented the Comprehensive Error Rate Testing Program and began producing error rates and estimates of improper payments to evaluate contractor and program performance. Since the inception of this program CMS has consistently reduced its improper payment error rate, from 9.8 percent in 2003 to 3.9 percent in 2007.

Calculating improper payment rates is only one step in the process to reduce improper payments. Remediation is another key part of CMS's efforts. CMS, through its Medicare claims processing contractors, uses the error rates to identify where problems exist and target improvement efforts. The cornerstone of these efforts is CMS's Error Rate Reduction Plan (ERRP), which includes agency-level strategies to clarify CMS policies and implement new initiatives to reduce improper payments. In the past, ERRPs have included plans to conduct special pilot studies and specific education-related initiatives. CMS also directs the Medicare claims processing contractors

Figure 1. Top Federal Programs With Improper Payments, Fiscal Year 2007



Source: Office of Management and Budget, *Improving the Accuracy and Integrity of Federal Payments* (January 31, 2008), available at: http://www.whitehouse.gov/omb/financial/fia/2007_ipia_final.pdf.

to develop local efforts to lower the payment error rate by targeting provider education and claim review efforts to those services with the highest improper payments. The type and nature of the errors in the program lend themselves to different types of corrective actions to fix them.

Some improper payments are best prevented when the Medicare claims processing contractors request and review the medical records associated with the claims prior to payment to ensure that payment is made only for Medicare-covered and medically necessary items and services furnished in the appropriate setting. Other improper payments can best be prevented by CMS or the Medicare claims processing contractors developing new or revised national or local coverage determinations, medical necessity criteria, or billing instructions to assist providers in understanding how to correctly submit claims for medical items and services and under what circumstances the services will be considered medically necessary. Still other improper payments are prevented when CMS and/or Medicare claims processing contractors educate the provider community about existing policies and remind them of the billing mistakes most commonly seen in the claims data.

CMS actions to safeguard Federal funds are not merely limited to claims processing actions and error rate programs. In 2006, Program Safeguard Contractors were established nationwide across all provider and supplier types. These specialized fraud fighters perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement, and coordinate Medicare fraud, waste, and abuse efforts with CMS's internal and external partners.

OIG and GAO Findings

Over the years, the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO) have issued reports describing the improper payments made by the Medicare FFS program. Although CMS, the Medicare claims processing contractors, and Quality Improvement Organizations (QIOs) have undertaken actions to recoup those overpayments and prevent future improper payments, it is difficult to prevent all improper payments, considering that more than 1 billion claims are processed each year. CMS has determined that most improper payments in the Medicare FFS program occur because a provider has submitted a claim to Medicare for a service that was not medically necessary or was incorrectly coded.

Legislation

Section 306 of the MMA authorized CMS to complete a demonstration project to determine whether RACs could be utilized efficiently and effectively in Medicare when tasked with identifying Medicare overpayments and underpayments and recouping overpayments. The MMA also mandated that a report to Congress be developed 6 months after the end of the demonstration to include information on the impact of the project on savings to the Medicare program and to provide recommendations on the cost-effectiveness of extending or expanding the project. In December 2006, in the TRHCA, Congress authorized the expansion of RACs nationwide by January 2010.

A full and open competition was used in selecting the RACs for the demonstration. CMS evaluated the original RAC proposals based on the bidders' technical ability to perform the Statement of Work tasks, their personnel and past performance, and the percent contingency fee that they required. Technical ability was the most important element, with the contingency percentage being secondary. Technical ability included knowledge of Medicare claims, knowledge of Medicare coverage policies, knowledge of the appeal system, understanding of the impact on providers, and ability to work with Medicare contractors, provider associations, and providers.

To fulfill the MMA requirements for a report to Congress to address the impact of the demonstration, CMS contracted with Econometrica, Inc., in June 2005 to support CMS in this work. The initial scope of work involved collecting and analyzing data focused on determining the effectiveness of the program in Medicare.

As the demonstration proceeded, CMS began to get inquiries from congressional offices regarding collections and the impact on providers. To provide

some level of transparency, CMS released a Fiscal Year 2006 Status Report, which included quantitative data such as the amount of collections, appeals, costs, and vulnerabilities.

For the next 15 months, CMS operated on parallel tracks. The RAC demonstration was continuing and coming to an end on one track. On the other track CMS was devising its expansion strategy. It was important for the RAC demonstration to continue and come to an end, because the demonstration developed the base for the expansion. The expansion strategy was driven by the lessons learned from the demonstration. These lessons related to issues that were raised by providers and associations, in addition to details that CMS investigated. Each issue helped improve the expansion strategy.

Purpose of This Report

The purpose of this report is to evaluate the RAC demonstration and share with all interested parties information about the demonstration. In addition to the reporting by the RACs and Medicare claims processing contractors, a number of other independent organizations, including Econometrica, Inc., the Gallup Organization, and AdvanceMed, provided data and assistance that were instrumental to the RAC demonstration and to the production of this report.

2. Background

Overview

The Medicare FFS program consists of a number of payment systems, with a network of contractors that process more than 1.2 billion claims each year, submitted by over 1 million providers such as hospitals, skilled nursing facilities (SNFs), physicians, labs, ambulance companies, and durable medical equipment (DME) suppliers. These contractors—called Medicare claims processing contractors—process claims, make payments to health care providers in accordance with the Medicare regulations, and educate providers about how to submit accurately coded claims that meet Medicare medical necessity guidelines. In addition, QIOs ensure the quality of services provided to beneficiaries.

Because of the large volume of claims submitted by providers, Medicare claims processing contractors pay most claims without requesting or scrutinizing the medical records associated with the services listed in the claim.

Circumstances Where Improper Payments Occur

Improper payments on claims can occur in the Medicare FFS program when:

- Payments are made for services that were **medically unnecessary** or did not meet the Medicare medical necessity criteria for the setting where the service was rendered (e.g., a claim from a hospital for three colonoscopies for the same beneficiary on the same date of service, whereas only one colonoscopy per day is medically necessary; or physical therapy provided in the inpatient setting when the therapy could have been safely and effectively provided in the outpatient setting).
- Payments are made for services that are **incorrectly coded** (e.g., the provider submits a claim for a certain procedure, but the medical record indicates that a different procedure was actually performed).

Medicare receives over 1.2 billion claims per year. This equates to:

- 4.5 million claims per work day
- 574,000 claims per hour
- 9,579 claims per minute.

- Providers fail to submit documentation to support the services provided when requested or fail to submit enough documentation to support the claim.
- **Other errors** are made, such as when the Medicare claims processing contractor pays the claim according to an outdated fee schedule, or the provider is paid twice because duplicate claims were submitted.

Medicare Secondary Payer (MSP) improper payments can occur in the Medicare FFS program when Medicare pays a claim that should have been paid by a different health insurance company. For example, when a Medicare beneficiary is employed and gets health benefits through his or her job, it is that health insurance company—not Medicare—that may be the primary payer of the beneficiary's health care services.

CMS Programs To Prevent Improper Payments

CMS actions to safeguard Federal funds are not merely limited to the claims processing actions and error rate programs. In 2006, Program Safeguard Contractors (PSCs) were established nationwide across all provider and supplier types. These specialized fraud fighters perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement, and coordinate Medicare fraud, waste, and abuse efforts with CMS internal and external partners.

There has been a growing concern that, even with all these efforts, the Medicare Trust Funds may not

be adequately protected against improper payments. Accordingly, Congress took action by passing legislation to enhance and support Medicare's current efforts in identifying and correcting improper payments. In Section 306 of the MMA, Congress directed the DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program (see Appendix A). Later, in Section 302 of the TRHCA, Congress required the DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010 (see Appendix B). The

Congress mandated the RAC demonstration and RAC permanent program to find and correct improper payments in the Medicare program.

RAC demonstration *did not* detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit program. As currently designed, the RAC permanent program also does not include the detection and correction of improper payments in either of these programs.

3. The RAC Demonstration

Purpose of the Demonstration

The RAC demonstration was designed to:

1. Detect and correct *past* improper payments in the Medicare FFS program; and
2. Provide information to CMS and the Medicare claims processing contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

Congress authorized CMS to use a different mechanism to pay the RACs. The Medicare claims processing contractors and QIOs are paid through funds appropriated by Congress. In contrast, CMS paid each RAC a contingency fee that was negotiated between CMS and the individual RAC. This demonstration was the first time the Medicare program has paid a contractor on a contingency fee basis; however, this type of payment methodology has been the accepted standard practice among private healthcare payers for more than 20 years.

The RACs were chosen through a competitive process. CMS held a full and open competition to select the three Claim RACs and two MSP RACs for the demonstration. In March 2005, CMS awarded the contracts and held a kickoff conference to prepare the RACs for the demonstration. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization, with approximately 25 percent of Medicare payments each year made to providers in these States. Initially, each Claim RAC had jurisdiction for a single State. The Claim RAC jurisdictions were expanded in the summer of 2007 to include the following three additional States: Massachusetts, South Carolina, and Arizona (see Table 1 for the names and jurisdictions of the Claim RACs and Table 2 for the names and jurisdictions of the MSP RACs).

The RAC Review Process

The RACs were bound by Medicare policies, regulations, national coverage determinations, local coverage determinations, and manual instructions when conducting claim reviews under the demonstration. In instances where there is no Medicare policy, the RACs reviewed claims based on accepted standards of medical practice at the time of claim submission. The RACs did not develop or apply their own coverage, coding, or billing policies. Similar to the Medicare claims processing contractors, the RACs used medical personnel, such as nurses and therapists, to review claims for medical necessity. In addition, each Claim RAC had a

Table 1. Names of Claim RACs and Their Jurisdictions

Name of RAC	Jurisdiction (Start Date)	Number of Claims Sent by CMS from Inception Through December 2007[a] (Millions)	Dollar Value of Claims Sent by CMS from Inception Through December 2007[a] (Billion Dollars)
Connolly Consulting (Connolly)	New York (March 2005)	414.5	$109.2
	Massachusetts (July 2007)	23.6	$ 18.6
HealthDataInsights (HDI)	Florida (March 2005)	466.8	$ 90.9
	South Carolina (July 2007)	8.7	$ 9.1
PRG-Schultz (PRG)	California (March 2005)	254.3	$ 89.2
	Arizona[b] (July 2007)	—	—
Total		**1,167.9**	**$317.0**

[a]No claims were sent in January, February, or March 2008.
[b]While contractually, Arizona was added to PRG's jurisdiction in July 2007, no Arizona claims were reviewed before the end of the RAC demonstration.
Source: Self-reported by the RACs.

Table 2. Names of MSP RACs and Their Jurisdictions

Name of RAC	Jurisdiction (Start Date)
Health Management Systems:	New York (February 2006)
Health Management Systems:	Florida (March 2005)
Diversified Collection Services:	California (March 2005)

physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request during complex review, manage the quality assurance procedures, and inform provider associations about the RAC demonstration.

The RACs analyzed claims data using their proprietary techniques to identify claims that clearly contained errors resulting in improper payments and those that likely contained errors resulting in improper payments. In the case of *clear* improper payments, the RAC contacted the provider to either collect any overpayment amounts or pay any underpayment amounts. This process is called an automated review. For example, a RAC could use information systems to search for claims for two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. The duplicate surgical procedures are clearly not medically necessary, should not have been billed twice by the hospital, and should not have been paid twice by the Medicare claims processing contractor. The RAC could perform automated review only when the improper payment was obvious (e.g., a duplicate claim) or a written Medicare policy, Medicare article, or Medicare-sanctioned coding guideline (e.g., CPT statement, CPT Assistant statement, Coding Clinic statement, etc.) existed and precisely described the coverage conditions.

In the case of claims that *likely* contained errors, the RAC requested medical records from the provider to further review the claim. The RAC could then make a determination as to whether payment of the claim was correct or whether there was an overpayment or an underpayment. This process is called a complex review. For example, a RAC could choose to review claims for beneficiaries admitted to an inpatient hospital due to chest pain. Because the RAC cannot determine from the claim alone whether the beneficiary meets the CMS medical necessity criteria for this setting, the RAC must examine the patient's medical record to determine whether the claim contained an improper payment.

RACs use the **same types of review staff** as the Medicare claims processing contractors.

These two review processes—automated review and complex review—are similar to those employed by the Medicare claims processing contractors to identify improper payments.

Claims Available for Review

From the inception of the demonstration through March 27, 2008, CMS provided each RAC with claims data from 2001 through 2007 for its jurisdiction (which accounted for an estimated total value of $317 billion). Some RACs focused their reviews on inpatient claims. Others targeted physician claims. CMS did not specify which claim types a RAC must review. It was up to each RAC to identify the claims most likely to contain an improper payment. For the demonstration, the RACs:

- Reviewed all claims in order to identify overpayments and underpayments that can be detected without medical record review, using their proprietary automated review software algorithms.
- Conducted medical record reviews of claims that the RAC thought—based on OIG/GAO/CERT reports, their knowledge of the health care industry, etc.—were likely to contain improper payments. These reviews entailed requesting medical records from the health care provider that submitted the claim. Though not required by CMS, some RACs developed self-imposed limits on the number of medical records they would request from a given provider over a 30- or 45-day period. Each RAC attempted to target these reviews to the greatest extent possible in order to minimize the burden on the provider and maximize the RAC's return on investment.
- Notified providers and directed the Medicare claims processing contractors to make adjustments for claims that were either overpayments or underpayments.

Claims Excluded from Review

The RACs could review any of the claims they were given, with the following exclusions:

- **Incorrect level of physician evaluation and management code.** CMS excluded these claims from RAC review while CMS considered a proposal by the American Medical Association that could have changed the way these services are reviewed. However, RACs were given the authority to review Evaluation & Management Services to look for other errors (e.g., duplicate payments, violations of Medicare's global surgery rules, definition of new patient, etc.). Despite being given the authority to review these services for other errors, very few of these types of claims were selected by the RACs for review during this time period.
- **Hospice and home health services.** CMS excluded these claims from the demonstration for administrative simplification purposes.
- **Payments made to providers under a CMS-conducted demonstration.**
- **Claims previously reviewed by another Medicare contractor.** CMS prohibited the RACs from reviewing claims that had already been reviewed by another Medicare contractor, so as not to unduly burden the provider with multiple requests for the same medical record. CMS created a RAC data warehouse to track information about claims reviewed by the RACs. Other Medicare contractors used this data warehouse to designate which claims had been previously reviewed and were therefore excluded from review by the RACs.
- **Claims involved in a potential fraud investigation.** Without divulging sensitive information, CMS excluded these claims from RAC review so as not to interfere with law enforcement's cases. Program Safeguard contractors also used the RAC data warehouse to indicate which cases were excluded from review by the RACs.

CMS oversight of the RAC demonstration has been facilitated by the RAC data warehouse. The RAC data warehouse was developed to provide CMS with an automated means of administering and overseeing the Claim RAC component of the demonstration. The RAC data warehouse serves as the repository for data about all claims with improper payments identified by the Claim RACs, and it is used by CMS to ensure that RACs do not review claims previously subjected to medical record review by another review entity (such as a QIO or Medicare claims processing contractor) or currently under a fraud investigation. This important tool minimizes the unnecessary burden to providers and prevents overlap with other Medicare program safeguard activities. The RAC data warehouse is also the principal data source for reporting improper payment findings to CMS and the public.

CMS developed the RAC data warehouse as a Web-based system intended to facilitate the activities of the multiple entities participating in the RAC demonstration project. These entities include: CMS, Claim RACs, Medicare claims processing contractors, QIOs, PSCs, and law enforcement agencies. The RAC data warehouse was designed to automate numerous administrative functions such as coordinating, tracking, and reporting on Claim RAC activity.

CMS tasked Econometrica, Inc., with assessing the completeness of certain data routinely entered into the RAC data warehouse. This process involved reconciling the number of claims and their associated dollar error amounts with "invoice data" (received from the Claim RACs) and "transaction data" (received from the Medicare claims processing contractors). The purpose of the reconciliation is to ensure that the number of improper claims and amounts found to be in error, as archived in the data warehouse, match the data that CMS receives from other sources. Econometrica's ongoing reconciliation work supports CMS in its oversight of the Claim RACs and in developing an archive of reliable program data.

Demonstration Costs

The cost to run the RAC demonstration was significantly less than the amount it returned to the Medicare Trust Funds. The demonstration costs fall into three categories: (1) *RAC contingency fees* include the fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments; (2) *Medicare claims processing contractor costs* are the funds paid to the carriers, fiscal intermediaries, and MACs for processing the overpayment/underpayment adjustments, handling appeals of RAC-initiated denials and other costs incurred to support

the RAC demonstration; and (3) *RAC evaluation, validation and oversight fees* are the funds paid to the RAC Evaluation Contractor, the RAC Data Warehouse Contractor, the RAC Validation Contractor, and the Federal employees who oversee the RAC demonstration. The costs of operating the RAC demonstration from inception through March 27, 2008, are shown in Table 3.

From its inception through March 27, 2008, the RAC demonstration spent only 20 cents for each dollar collected, calculated as follows: $201.3 million (cost) / $992.7 million (total collections) = $0.20. These numbers were calculated based on actual collections and reimbursements.

In addition to the direct costs associated with the operation of the RAC demonstration, CMS acknowledges that costs were incurred by entities not directly involved in the demonstration, such as the Qualified Independent Contractors (QICs) and Administrative Law Judges (ALJs) who processed the second- and third-level appeals. CMS also acknowledges that there were costs to those providers who were selected for medical record review and those providers who chose to appeal the RAC determinations. CMS is unable to quantify these costs for purposes of this report.

Table 3. Cost of Operating the Medicare RAC Demonstration: Cumulative Through 3/27/08, All RACS

Cost Categories	Costs (Million Dollars)
RAC contingency fees	$ 187.2
Medicare claims processing contractor costs	$ 8.7
RAC evaluation, validation, and oversight expenditures	$ 5.4
Total	**$ 201.3**

Source: RAC vouchers and Contractor Accounting Financial Management System (CAFM).

These cost data indicate that the RAC demonstration was a cost-effective program, successful in returning improper payments to the Medicare Trust Funds. CMS anticipates that changes planned for the RAC permanent program will result in an even more cost-effective program in the future.

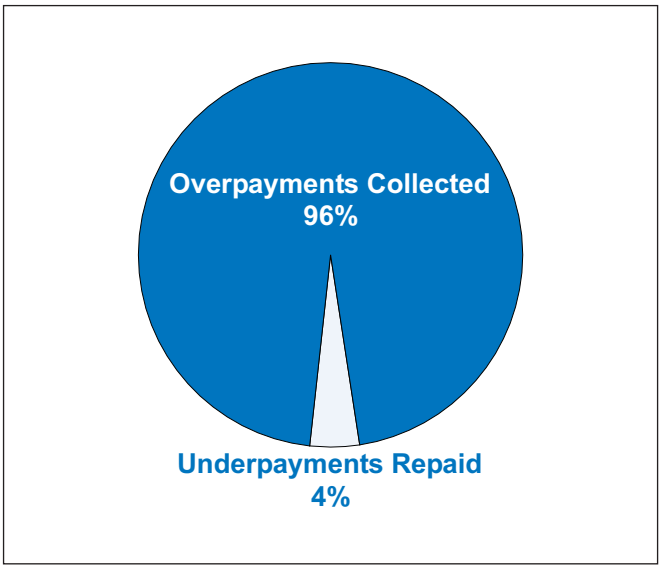
4. Results of the RAC Demonstration

The RACs succeeded in correcting over $1.03 billion of Medicare improper payments. Over 96 percent of these improper payments were overpayments that were collected from providers. The remaining 4 percent were underpayments that were repaid to providers (see Table 4 and Figure 2). During a similar time period, the Medicare claims processing contractors in New York, Florida, and California corrected over $13 million in improper payments and prevented an additional $1.8 billion in improper payments by denying claims before they were paid. Unlike RACs, which perform revisions only *after* a claim has been paid, Medicare claims processing contractors may automatically review claims or choose claims for medical review *before* they are paid. The $1.8 billion figure includes both automated and complex prepay review. The disparity between overpayments and underpayments is even greater in the reviews performed by the Medicare claims processing contractors (99.9 percent of overpayments collected vs. <0.1 percent of underpayments repaid).

Medicare Secondary Payer RACs

Prior to the MSP RAC demonstration, several companies would assert to CMS that they had insurance

Figure 2. Overpayments Vs. Underpayments



Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Table 4. Improper Payments Corrected by the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs
(Million Dollars)

RAC	Overpayments Collected[a]	Underpayments Repaid[b]	Total Improper Payments Corrected
Connolly	$ 266.1	$ 4.3	**$ 270.4**
HDI	$ 396.1	$ 20.8	**$ 416.9**
PRG	$ 317.8	$ 12.7	**$ 330.5**
Claim RAC Subtotal	***$ 980.0***	***$ 37.8***	***$ 1,017.8***
HMS	$ 1.3	$ 0.0	**$ 1.3**
DCS	$ 11.4	$ 0.0	**$ 11.4**
MSP RAC Subtotal	***$ 12.7***	***$ 0.0***	***$ 12.7***
Grand Total	**$ 992.7**	**$ 37.8**	**$ 1,030.5**

[a]Collected is defined as overpayments that have been recovered from providers and deposited.
[b]Repaid is defined as underpayments that have been paid back to the provider. MSP RACs were not tasked with identifying underpayments.
Note: For this Evaluation Report, CMS lists all dollars actually collected and repaid between March 2005 and March 2008. In contrast, reporting for the FY 2006 RAC Status Document was based on overpayment and underpayment *notification letters* that were sent to providers and to the Medicare claims processing contractor during the fiscal year.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

data available to them that would identify a significant number of MSP occurrences. Many companies perform this type of work with Medicaid State agencies, and some felt that their Medicaid methodologies, which have proven to be very successful, would easily translate into the Medicare environment. The payment methodology for the Medicaid contracts was normally contingency based. Since Section 306 was not prescriptive regarding just the review of claims, CMS felt it was the opportune time to determine whether a MSP RAC could be effective in the Medicare environment. However, the MSP RACs collected considerably fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million).

Initially two MSP RAC contracts were awarded. Approximately one year into the demonstration CMS awarded a third. The MSP RACs initially identified a large number of potential improper payments; however, the majority of those selected overpayments were not MSP occurrences. More specifically, the MSP RACs had identified a number of beneficiaries with reported income, which appeared to be wages. This would indicate that the beneficiaries were employed and should be receiving health coverage from their employers, not Medicare. Upon further investigation, the MSP RAC learned that the income was in the form of retirement benefits rather than wages. Thus, Medicare was the rightful payer.

The MSP RACs were responsible for obtaining and reviewing insurance information to determine whether Medicare should have been the primary payer of a claim or the beneficiary had other insurance that may have been responsible for the primary payment. However, one of the greatest challenges for the MSP RACs was determining whether a beneficiary was in a retired status. The insurance information available to the MSP RACs did not indicate whether payments were made as wages or as retirement payments. This resulted in a large number of false positives, which challenged the MSP RACs throughout the entire demonstration.

The MSP RACs were very creative and attempted numerous activities to identify MSP occurrences. They attempted to obtain access to the States' wage and earnings file but were only successful in the State of Florida. (The MSP RACs might have been able to obtain access in the State of New York, but the demonstration ended.) This helped identify some MSP occurrences, but the numbers still outweighed the original potential suggested by the MSP RACs.

The MSP RACs were able to identify certain areas of MSP occurrences. For example, the MSP RAC in California was very successful identifying occurrences at universities where tenured professors normally teach well past their Medicare eligibility age. This was already a known occurrence to CMS and CMS had been working with some of the larger university systems to share data. CMS develops Voluntary Data Sharing Agreements (VDSA) with employers to determine active employees. Some universities that were reluctant to enter into a VDSA with CMS expressed more interest after the MSP RAC began identifying a large number of occurrences.

However, it is important to note that CMS had already been saving a significant amount of Medicare dollars each year by identifying situations where Medicare should not have been the primary payer. This work was completed by a Coordination of Benefits contractor, which consolidated much of the prepay work (questionnaires to beneficiaries and identifying occurrences prior to the payment of the claim), and through the Medicare claims processing contractors, who identified potential leads and collected amounts that were paid in error. During the course of the RAC demonstration, CMS consolidated the collection efforts of the collection of the MSP debt into one national contractor. The MSP RACs were seen as an addendum to the current CMS process. CMS did not significantly alter any of the processes for the MSP RAC demonstration.

While the MSP RACs collected considerably fewer overpayments ($12.7 million) than the Claim RACs ($980.0 million) CMS does not consider the MSP RAC demonstration to be a failure. Although the MSP RACs tested a number of possible methodologies to identify the MSP occurrences without much success and the limited success they did have was not new to CMS, the MSP RAC demonstration proved that CMS's current efforts to identify MSP

occurrences are working and are appropriate. It also highlighted the need for mandatory insurance reporting and access to the National Database of New Hires (NDNH) which is currently used by the Administration of Children and Families for child support enforcement and by the Department of Education for the collection of defaulted student loans.

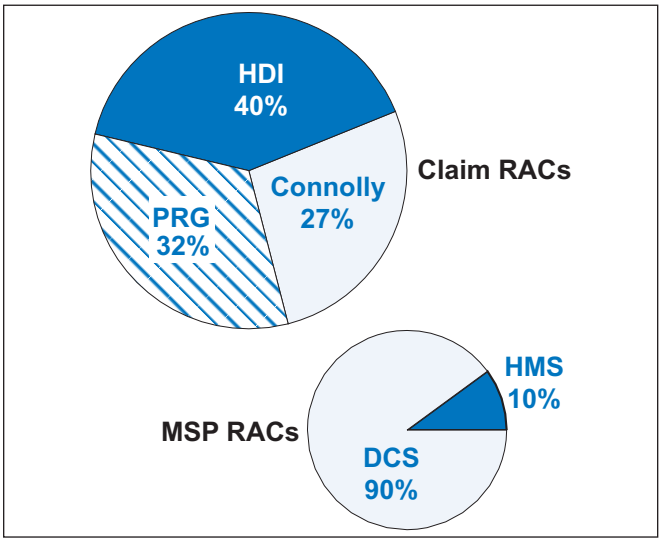
Claim RACs

The Claim RACs corrected $980.0 million in overpayments and $37.8 million in underpayments. HealthDataInsights (HDI), the Claim RAC for Florida and South Carolina, collected approximately 40 percent of the overpayments; PRG-Schultz (PRG), the Claim RAC for California, collected approximately 32 percent; and Connolly Consulting (Connolly), the Claim RAC for New York and Massachusetts, collected approximately 27 percent (see Figure 3).

Providers can use the findings in Appendix P to help improve the accuracy of their claim submissions and thereby avoid future improper payments.

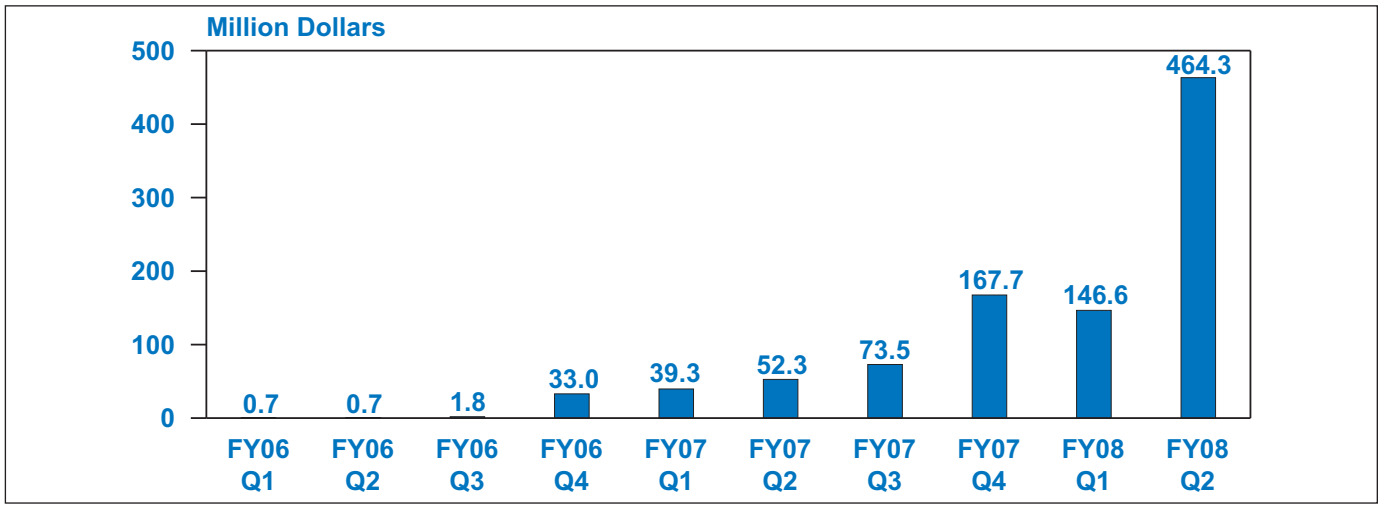
Claim RACs' improper payment correction efforts improved over time (Figure 4). This was due in part to the nature of the contingency fee arrangement. Because each Claim RAC started with a Medicare-provided budget of $0, each had to invest its own capital to hire the staff to start reviewing Medicare claims for potential improper payments. When those few initial reviews enabled the Claim RACs to correct actual improper payments, CMS paid them contingency fees, which in turn allowed the Claim RACs to hire more reviewers. Further, improvements occurred over time because of the increased experience with the Medicare recovery process, staffs becoming more familiar with Medicare policies, better collaboration with Medicare claim processing contractors, and improved provider outreach (see Appendix C for yearly corrections and quarterly collections by the Claim RACs). CMS expects that the same "ramp up" period will be seen in

Figure 3. Overpayments Collected



Note: Percentages shown for Claim RACS do not sum to 100 due to independent rounding.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Figure 4. Overpayments Collected by Quarter: Claim RACs Only



Source: RAC invoice files and RAC Data Warehouse.

the permanent RAC program. Less "ramp up" time will be needed by an incumbent Claim RAC, should one of them win a contract.

Most Medicare claims were unaffected by the RACs. Over the life of the RAC demonstration (through March 27, 2008), CMS gave the Claim RACs 1.2 billion claims, with a value of $317.0 billion. Although $1.03 billion in improper payments corrected by RACs over 3 years seems very large, it is less than 1 percent of the dollar value of all claims the Claim RACs were given. According to the *Improper Medicare FFS Payments Report, FY2007* (also known as "the CERT report"), the Medicare estimated improper payment rate is 3.9 percent (see Appendix D). For comparison purposes, Claim RACs identified and corrected improper payments on 0.3 percent of all the payments that were available for review over the life of the demonstration (see Table 5).

Even after subtracting the amounts repaid to providers for underpayments, the amount overturned on appeal, and the costs of operating the RAC demonstration, the RACs returned $693.6 million to the Medicare Trust Funds (see Table 6). This number includes appeals overturned through March 27, 2008. Providers have 120 days to appeal from the date of the claim adjustment, and CMS anticipates that most first-level appeals of Claim RAC determinations will have been filed by July 1, 2008. Further details regarding costs can be found on page 13.

Table 5. Improper Payments Corrected by Claim RACs as a Percentage of All Medicare Claims Received: Cumulative Through 3/27/08, Claim RACs Only

Dollar Value of All Claims Given to Claim RACs by CMS (Billion Dollars)	Improper Payments Corrected by Claim RACs (Billion Dollars)	Percent Corrected
$317.0	$1.0	0.3%

Source: The $317.0 billion figure was self-reported by the Claim RACs. Payments corrected were verified by the RAC invoice files and RAC Data Warehouse.

Approximately 85 percent of the overpayments collected by the Claim RACs were from inpatient hospitals (Figure 5). The *Improper Medicare FFS Payments* report from November 2007 (based on a review of a random sample of claims) found that 45.4 percent of the improper payments in Medicare were made to inpatient hospitals. Several factors may explain the Claim RACs' relatively high rate of improper payment identifications in the inpatient hospital settings. Because the Claim RACs were paid on a contingency fee basis, they establish their claim review strategies to focus on high-dollar improper payments, like inpatient hospital claims, which gave them the highest return with regard to the expense of reviewing the claim and/or medical record. CMS anticipates that the permanent RACs will adopt a similar strategy at first.

Figure 6 shows the overpayments collected under the RAC demonstration, net of appeals and by error type. Payments for claims that did not meet Medicare's medical necessity criteria for that service or setting and payments for claims that were incorrectly coded each account for more than 35 percent of overpayments corrected by the Claim RACs. Of the $828.3 million improperly paid to inpatient hospitals, about 36 percent was due to incorrect coding and 41 percent was due to the service being rendered in a medically unnecessary setting—often referred to as "wrong setting" improper payments (see Appendix E). These are situations where the beneficiary needed care but did not need to be admitted to the hospital to receive that care.

Appendixes F and G provide more information on the errors and service-specific vulnerabilities that

Table 6. Summary of Net Savings in the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs

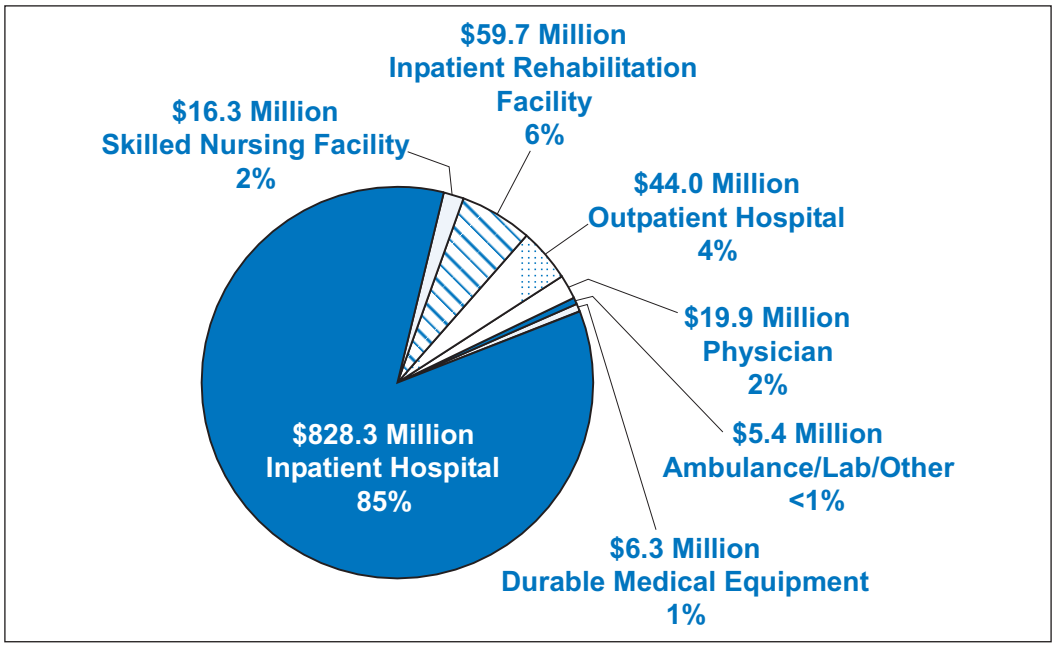
(Million Dollars)

Overpayments Collected		Underpayments Repaid		Amount Overturned on Appeal		PRG IRF Re-reviews		Costs To Operate RAC Demonstration		Net Savings Back to the Trust Funds
$992.7	-	$37.8	-	$46.0	-	$14.0	-	$201.3	=	**$693.6**

Source: FFS collections and reimbursements were verified by RAC invoice files and the RAC Data Warehouse. MSP RAC deposits were verified by the CMS Accounting Division.

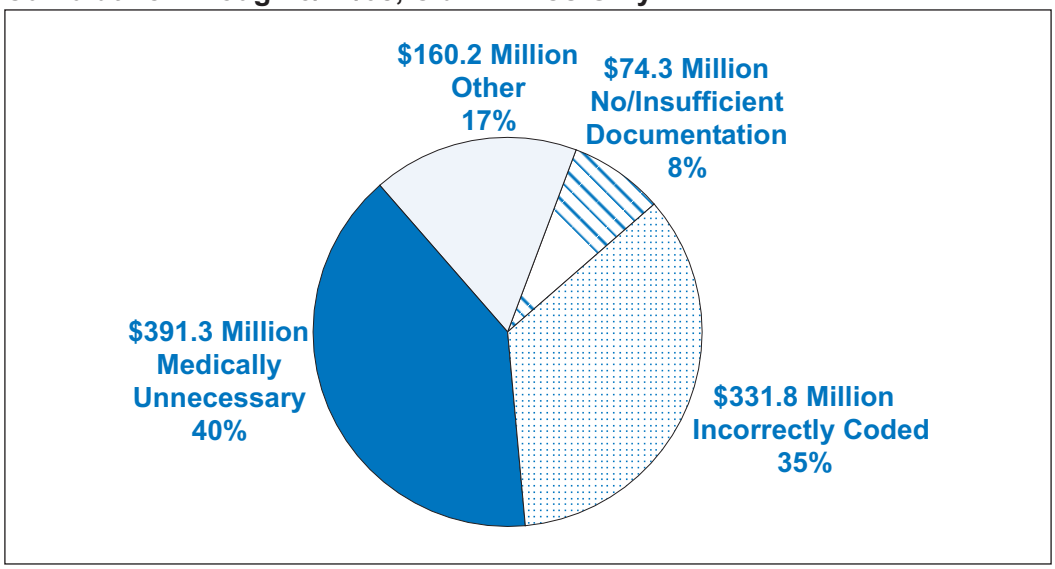
resulted in RAC-identified overpayments. Appendix H provides information on service-specific vulnerabilities that resulted in RAC-identified underpayments. These data were self-reported by the Claim RACs and were not gathered from the RAC data warehouse. All data in this section are net of appeals that were known as of March 27, 2008. For example, if there were $10 million in overpayments collected for a particular service but $1 million of these overpayments were overturned on appeal, the data would show $9 million.

Figure 5. Overpayments Collected by Provider Type: Cumulative Through 3/27/08, Claim RACs Only



Note: These data are *not* net of appeals.
Source: RAC invoice files and RAC Data Warehouse (ratios needed to calculate Physician percentages from Ambulance/Lab/Other data were self-reported by the Claim RACs).

Figure 6. Overpayments Collected by Error Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only



Source: Self-reported by the Claim RACs.

Provider Impact

The RAC demonstration had a limited financial impact on most providers. Figure 7 shows improper payments as a percentage of Medicare Part A revenue for hospital providers in fiscal years 2006 through 2008. On average, over 84 percent of the hospitals in PRG's and HDI's jurisdictions had their Medicare revenue impacted by less than 2.5 percent. Over 94 percent of hospitals in Connolly's jurisdiction had their Medicare revenue impacted by less than 2.5 percent. Appendixes I, J, and K include more data on provider impacts.

Appeals Statistics

From the inception of the RAC demonstration through March 27, 2008, providers chose to appeal only 14.0 percent (73,266) of the Claim RAC determinations. Overall, the data indicate that of all the Claim RAC overpayment determinations (525,133), only 4.6 percent (24,376) were overturned on appeal (see Table 7).

By comparison, from FY 2005 to FY 2007, the Medicare claims processing contractors' medical review departments in all States made improper payment determinations on 312 million claims. These include both prepayment and postpayment determinations. Providers chose to appeal 4 percent of these determinations (12.2 million claims). Of all the determinations made by Medicare claims processing contractors, only 2.3 percent (7.2 million claims) were overturned on appeal. (See Table 8 for a comparison of appeal rates for Medicare claims processing contractors and the RACs.)

Only 4.6 percent of RAC determinations were fully or partially **overturned on appeal**.

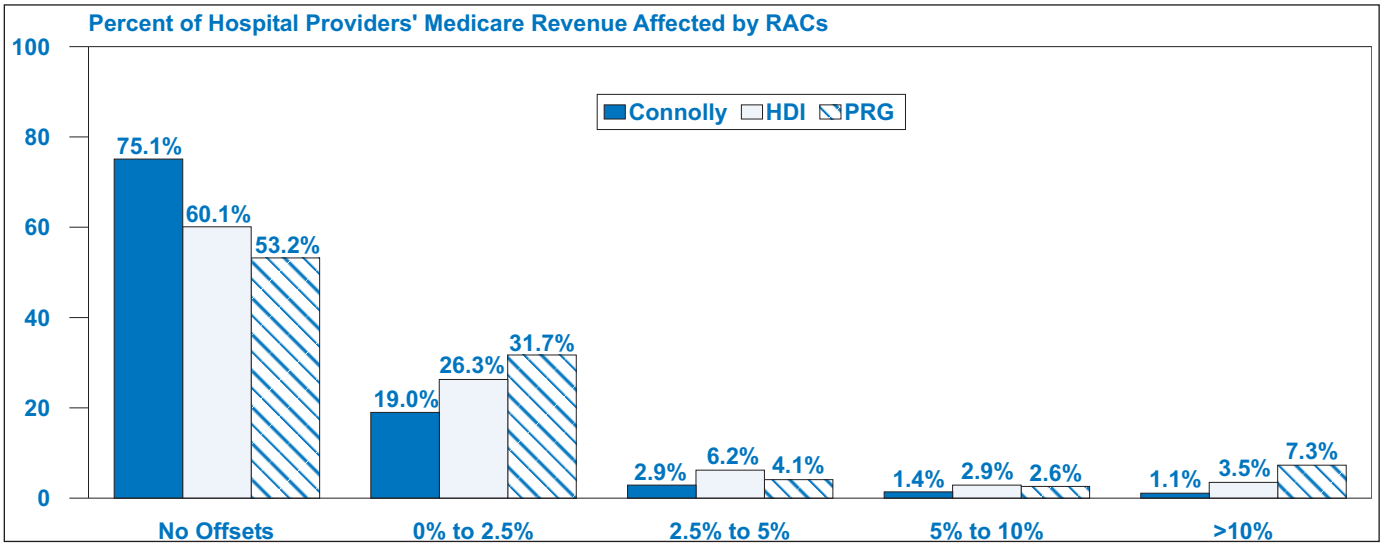
The demonstration required that if a RAC determination was overturned on the first level of appeal, the RAC was required to pay back their contingency fee. If the RAC determination was overturned at the second or higher level of appeal, the RAC was not required to pay back its contingency fee, although one RAC (PRG) volunteered to do so. A number of providers voiced concern about the perception created by the Claim RAC retaining a contingency fee on a claim when the RAC determination was overturned on second- or third-level appeal (see Chapter 6, Issue #8).

Table 7. Claims Overturned on Appeal: Cumulative Through 3/27/08, Claim RACs Only

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	73,266
Number of claims with appeal decisions in provider's favor	24,376
Percentage of appealed claims with a decision in provider's favor	33.3%
Percentage of claims overturned on appeal	4.6%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

Figure 7. Financial Impacts on Hospital Providers: Fiscal Years 2006-2008, Claim RACs Only



Source: Self-reported by the Claim RACs.

In addition to the data in Table 7, as of May 1, 2008, there are an additional 3,009 claims (valued at $25.3 million) pending at the QIC and ALJ levels of appeals—the second and third levels of appeals, respectively (see Table 9). At this time, CMS is not able to determine the number of appeals pending at the first level of appeal. CMS can estimate that, as of May 1, 2008, there are claims valued at $255.1 million where the provider still has the right to file a first-level appeal. For this reason, the tables and figures in this report will be updated on a regular basis through the summer of 2008.

Table 8. Comparison of Medicare Contractors' Appeal Statistics

	Percentage of Denials Appealed by Providers	Percentage of Appealed Denials with Decision in Provider's Favor	Percentage of All Denials with Decision in Provider's Favor
Claims processing contractors[a]	4.0%	59.0%	2.3%
RACs[b]	14.0%	33.3%	4.6%

[a]For all States from FY 2005 to FY 2007.
[b]From March 27, 2005, through March 27, 2008.
Note: Appeals by Medicare claims processing contractors include those in all States.
Source: Medicare claims processing contractors.

Table 9. Pending Appeals as of 5/1/08

Level of Pending Appeal	Number of Claims	Value of Claims (Million Dollars)
Pending at QIC	2,181	$ 2.8
Pending at ALJ	828	$ 22.5
Timeframe for appeal still open	—	$ 255.1

Source: Ad-QIC and RAC Data Warehouse.

5. Independent Verification of Demonstration Results

To ensure the validity of the data underlying the demonstration, CMS tasked Econometrica, Inc., with assessing the completeness of certain data that were routinely entered into the RAC data warehouse. This process involved reconciling the number of claims and their associated dollar error amounts with invoice data (obtained from the Claim RACs) and transaction data (obtained from the Medicare claims processing contractors). The purpose of the reconciliation was to ensure that the number of improper claims and amounts found to be in error that are archived in the data warehouse match the data CMS received from other sources. Econometrica's data reconciliation is completed through fiscal years (FY) 2006 and 2007, and they are continuing to reconcile data through FY 2008. This is an additional layer of data verification beyond CMS's own efforts. Econometrica's ongoing reconciliation work supports CMS in its oversight of the Claim RACs and in developing an archive of reliable program data. Econometrica's performance was measured through the timely submission of data to its CMS project officer.

Econometrica also supported CMS by verifying certain summary data included in this report and documenting the results of that effort. This work included analyzing numerous RAC invoice files and selected data in the RAC data warehouse to verify results derived by CMS and documenting the methodology used to calculate the findings. This effort provided a separate, third-party verification of CMS's findings.

In addition, through a contract under the supervision of Econometrica, the Gallup Organization conducted an independent survey of providers' perceptions of the RAC program. Between May 2007 and July 2007, using computerized telephone interviews, the Gallup Organization contacted a sample of more than 500 providers who had received either a medical record request letter or an overpayment recoupment from a RAC at least once in the year before the survey. These independent survey results established an important baseline for provider satisfaction with the RAC demonstration. The Gallup Organization was a subcontractor to Econometrica. The Gallup Organization's performance was measured through its timely completion of the provider survey.

AdvanceMed, the Claim RAC Validation Contractor (RVC), provided external validation and helped ensure the accuracy of the RAC claim determinations by conducting independent, third-party reviews of improper payments identified by the RACs (see Appendix N for a description of the review procedures used by the RVC during the demonstration). Beginning in September 2007, initial batches of claim reviews were conducted at CMS's request. Additional claims were randomly selected by Econometrica and independently reviewed by AdvanceMed. AdvanceMed also provided validation of the accuracy of some of the new issues the Claim RAC wished to pursue for potential improper payments. AdvanceMed's performance was measured through the timely submission of review findings to CMS.

Finally, the RAC program was structured in such a way as to require that provider appeals of RAC determinations be submitted not to the RAC, but instead to the Medicare claims processing contractors. The claims processing contractors independently reviewed all RAC improper payment determinations that providers appealed. The claims processing contractors followed the standard Medicare appeals process when hearing RAC claims, including the timeframes for filing, etc.

Supported by these independent sources, CMS prepared this evaluation of the RAC demonstration in an effort to make data available to interested parties and provide a mechanism for sharing current data as the normal appeals process runs its course. Currently, CMS is planning to release monthly updates to this report through the summer of 2008.

6. Lessons Learned from the RAC Demonstration

A number of questions were identified during the preliminary planning of the RAC demonstration. Responses to those questions were one of the metrics used to evaluate the effectiveness of the RAC demonstration.

- **CMS found that it is possible to gradually expand the RAC program.**
  When the RAC demonstration began, RACs were present in only three States—New York, Florida, and California. When the Tax Relief and Health Care Act of 2006 was passed, requiring CMS to make the RAC program permanent and nationwide by January 1, 2010, CMS decided to expand the demonstration into several additional States. CMS found that it is possible to expand the jurisdiction of the RACs but also learned how important good provider communication is during such an expansion. Communication was accomplished by CMS through the use of conference calls and visits to provider organizations in each affected State. Therefore, CMS has decided not to expand to all 50 States via a "big bang" approach in December 2009. Instead, CMS plans to phase in the new RACs gradually, beginning in the summer of 2008 through December 2009. CMS believes that this gradual ramping up will allow for the formation of strong communication channels with the provider community, which are necessary for the success of the program.

- **CMS found that RACs can find improper payments in Medicare.**
  All three Claim RACs found a significant volume of improper payments.

- **CMS determined that providers would not appeal every RAC overpayment determination.**
  Providers appealed only 14.0 percent of RAC determinations from the inception of the demonstration through March 27, 2008. Of all RAC determinations, only 4.6 percent were overturned on appeal.

Both the RAC demonstration and the RAC permanent program allow CMS and the Medicare claims processing contractors to **target actions aimed at preventing future improper payments**.

- **CMS learned that the cost to run the RAC demonstration was significantly less than the amount it returned to the Medicare Trust Funds.**
  The total costs were 20 cents for each dollar collected.

- **CMS determined that contingency fee contractors were willing to spend time on provider outreach activities (meeting with providers, addressing provider concerns, etc.).**
  All RACs developed working relationships with the provider organizations in their jurisdictions.

- **CMS learned that contingency fee contractors did not disrupt Medicare's anti-fraud efforts.**
  The RAC demonstration succeeded in developing the cooperation needed to ensure that RAC activities did not compromise ongoing law enforcement investigations. The relationships built during the RAC demonstration have improved the overall coordination of these activities and will provide a framework for the nationwide expansion of the RAC permanent program.

- **CMS determined that it is administratively possible to pay contractors on a contingency fee basis.**
  CMS developed a mechanism to pay the RACs using a voucher process. All collections were processed by Medicare claims processing contractors and were reconciled with RAC vouchers before contingency fee payments were made to the RAC.

- **CMS determined that it is possible find companies willing to be paid on a contingency fee basis.**

The RAC demonstration also highlighted certain issues and processes that needed improvement. Some of the major concerns are discussed below. Improvements CMS has made to the RAC permanent program as a result of the demonstration are summarized in Table 10.

ISSUE #1: Medicare claims processing systems were overwhelmed by the high volume of improper payments uncovered by Claim RACs. The Claim RACs submitted an unprecedented volume of claims during the demonstration to the Medicare claims processing contractors for re-adjudication. This created severe backlogs within some of the Medicare claims processing contractors early in the demonstration. These backlogs not only delayed the recovery of overpayments but, with regard to older claims, the backlogs also resulted in many lost recoveries due to the 4-year limitation on overpayment review activities. This backlog also created time delays (often of several months) between the date of a Claim RAC letter to a provider indicating the amount to be collected and the date of the actual collection. This was confusing to providers.

CHANGE: To address this problem, CMS initially increased the staff at the Medicare claims processing contractors and worked with the RACs to establish procedures to consolidate claims in order to improve efficiency and reduce the backlog. Later, CMS began to implement changes in the claims processing computer systems to automate the adjustment process and eliminate the need for costly and time consuming manual intervention. Importantly, this computer change ensured that overpayment recovery or underpayment reimbursement occurred promptly, reduced provider confusion, and ultimately will minimize the burden on the Medicare claims processing contractors.

ISSUE #2: Not all Claim RAC issues were "validated" prior to widespread review. IRF providers in California were concerned that PRG was misinterpreting the CMS medical necessity criteria for IRF services and therefore making inaccurate overpayment determinations (see Appendix O). Other providers in all three demonstration States were concerned that the Claim RACs could be misinterpreting a CMS coverage or payment policy. Providers were universally concerned that CMS would not even become aware of such RAC mistakes until after a significant number of providers had spent money on copying and sending medical records and filing appeals.

CHANGE: In August 2007 CMS instituted a new issue review process and contracted with an independent third-party review entity, AdvanceMed, to be the Claim RAC Validation Contractor (RVC). For each new issue a RAC wished to pursue for potential improper payments, the RAC submitted to CMS information on the issue, including the provider type, error type, policy violated, and potential improper payment amount per claim. CMS staff reviewed each issue and determined whether the RAC could proceed with its review, or whether the issue should be reviewed by the RVC. If the issue required RVC review, the RAC sent the RVC a small sample of claims (and medical records if complex review was required). The RVC then issued a recommendation to CMS on whether the RAC should proceed with a full-scale review. CMS will continue this process for all new issues when the RAC permanent program begins and will require that the new issues be posted online. Thus, a RAC cannot perform any automated or complex reviews in excess of 10 medical records without CMS approval.

ISSUE #3: Providers felt that there was no measure of RAC accuracy. Some providers were concerned that the Claim RACs could be making inaccurate claim determinations, but CMS would not know since providers sometimes choose not to appeal a RAC-initiated overpayment with which they disagree. These providers may believe that the effort and cost involved in filing an appeal outweigh the benefits of winning an appeal.

CHANGE: CMS tasked the RVC with reviewing a random sample of overpayment claims from each Claim RAC. The RVC has been valuable in ensuring the accuracy of the overpayment decisions made by each RAC. CMS will publicly release each permanent RAC's accuracy score.

ISSUE #4: Hospitals could not resubmit claims when necessary services were provided in the wrong setting.

CHANGE: During the RAC demonstration, CMS waived the "timely claim filing" limits and allowed hospitals to resubmit claims for outpatient ancillary services in these situations. CMS is exploring whether it is possible to continue this waiver during the RAC permanent program.

ISSUE #5: A four-year look-back period is too long. Many providers felt that the four-year look-back period conflicted with the regulation stipulating that providers were liable only for repaying overpayments within three years of the original claim payment.

CHANGE: CMS has changed the look-back period under the RAC permanent program to only three years and established a maximum look-back date of October 1, 2007.

Table 10. Improvements Made to the RAC Permanent Program

Issue	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date - date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP included	Yes	No
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
RAC claim status Web page	Not Required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

ISSUE #6: Fulfilling medical record requests can be burdensome on providers. During the RAC demonstration, CMS suggested that each Claim RAC establish limits on the number of medical records they would request from a provider. Two RACs set a number limit over a 30- or 45-day period, and one RAC used a limit based on the financial impact on a provider. Thus, there was significant variation in the limits imposed across the demonstration. The limits were a single number and did not expand or contract based on the size of the provider. Thus, the same limit was used with a 700-bed hospital and a solo-practice physician office.

CHANGE: In the RAC permanent program, CMS will establish a uniform "sliding-scale" limit across all four RACs. Thus, the limit will be higher for large facilities and lower for small providers. CMS will make these limits available to the public before the first medical record request is issued.

ISSUE #7: The RACs paid back contingency fees only at the first level of appeal. Under the RAC demonstration, the RACs were required to return contingency fees if the claim determination was overturned on first-level appeal. Demonstration RACs were allowed to retain their contingency fees on determinations overturned on second- or third-level appeal. CMS chose this methodology during the initial planning of the RAC demonstration, to quell fears that no companies would bid to become RACs if they would be required to return contingency fees for determinations overturned years later. Also, because the demonstration was authorized for only three years and it can often take more than three years for a claim to complete the entire appeals process, CMS did not have the legal authority to take back money from companies no longer under contract. Providers were concerned that by allowing the RACs to retain contingency fees on overturned decisions, CMS was perpetuating the feeling that the RACs would make inaccurate determinations just to increase their fees.

CHANGE: In the RAC permanent program, CMS will require all RACs to refund any contingency fees they received if an overpayment determination is overturned at any level in the appeals process.

ISSUE #8: Providers felt that lack of a physician presence at the RAC equated to claims being erroneously denied.

CHANGE: CMS has required each RAC to hire a physician Medical Director to oversee the medical record review process, assist nurses, therapists, and certified coders upon request, manage quality assurance procedures, and inform provider associations about the RAC permanent program.

ISSUE #9: There was no electronic platform for tracking status. Many providers wanted to closely monitor the status of their medical record submissions to the RACs. This required providers to place frequent phone calls to RACs and to read a list of case ID numbers to see whether the RAC had received the medical records.

CHANGE: By 2010, CMS will require the new, permanent RACs to maintain a Web portal to display to each provider the status of all RAC medical record requests.

ISSUE #10: Provider confusion existed about the roles of the various Medicare contractors involved with detecting and correcting improper payments.

CHANGE: CMS will post a fact sheet to its Web site to clarify the roles of Medicare claims processing contractors, CERT contractors, QIOs, and RACs, as summarized in Table 11.

Table 11. Roles of Medicare Review Contractors

Improper Payment Function	Contractor Performing Function
Preventing future improper payments through pre-pay review and provider education	Medicare claims processing contractors
Detecting past improper payments	RACs
Measuring improper payments	CERT
Performing higher-weighted DRG reviews and expedited coverage reviews	QIOs

ISSUE #11: The RACs were inconsistent in documenting their "good cause" for reviewing a claim. Although the Departmental Appeals Board ruled that lack of good cause is not grounds to file an appeal, CMS continues to believe that RACs should consistently document their good cause for choosing a claim for review.

CHANGE: CMS issued instructions to the RACs requiring that they consistently document their "good cause" for reviewing a claim.

ISSUE #12: MSP RACs collected few improper payments.

CHANGE: CMS has decided not to contract with separate MSP RACs in the permanent RAC program.

ISSUE #13: CMS's nondisclosure of RAC contingency fees increased apprehension for some providers.

CHANGE: In the RAC permanent program, CMS will publicly disclose the RAC contingency fees.

Future Improper Payments Can Be Avoided

An important outcome of the demonstration is that the Claim RAC findings can be analyzed by CMS and the Medicare claims processing contractors to identify corrective actions that can be implemented to prevent future improper payments. Further, providers can use these findings to help ensure that they are submitting correctly coded claims for services that meet Medicare's medical necessity criteria. Although some of the RAC-identified improper payments were due to claims processing errors, the majority of the improper payments were due to providers billing for services that were incorrectly coded or did not meet Medicare's medical necessity policies. By establishing strong internal controls, hospitals can use these findings to train coders, physicians, medical record staff and others to help minimize future improper payments. Appendixes G and F provide information on the top services and errors that resulted in RAC-identified overpayments. Appendix H provides a list of the top services with RAC-identified underpayments.

Provider education about RAC-identified problem areas is a critical component of CMS's strategy to prevent future improper payments. By educating providers about the coding and medical necessity rules, providers can submit future claims correctly and thereby avoid being overpaid. Even claims processing contractors in other States can use these findings to help reduce their local error rates by analyzing whether any of these improper payments are occurring in their States.

CMS and the Medicare claims processing contractors have already taken a number of actions aimed at reducing improper payments. Several claims processing edits were installed to deny obvious errors, such as excessive units for Neulasta and colonoscopies. CMS also held regular conference calls with Medicare contractors throughout the demonstration to discuss the Claim RAC findings and will continue to do so during the permanent program. However, CMS is unable to determine at this point whether the Medicare claims processing contractors in the RAC States are able to lower their paid claims error rates more rapidly than Medicare claims processing contractors in other States.

7. Implementation of the Permanent RAC Program

CMS will gradually implement the RAC permanent program nationwide. Due to the importance of protecting the Medicare Trust Funds, Congress included Section 302 in TRHCA, which requires the Secretary to implement the RAC program throughout the country by no later than January 1, 2010 (see Appendix B). CMS is undertaking a number of initiatives to gradually implement the RAC permanent program.

CMS has begun the expansion process by initiating a full and open competition for four permanent RACs to begin after the end of the RAC demonstration in March 2008. (See Appendix Q for a map of future RAC jurisdictions.)

CMS has also developed an effective strategy to ensure that the RAC permanent program will not interfere with the transition from the old Medicare claims processing contractors to the new Medicare claims processing contractors, called Medicare Administrative Contractors (MACs). This strategy will allow the new MACs to focus on claims processing activities before working with the RACs. Generally, the RAC blackout period will be:

a. 3 months before a MAC begins processing claims for a given State

b. 3 months after a MAC begins processing claims for a given State.

In addition, CMS and the permanent RACs will undertake aggressive provider outreach. As soon as practical after the award of the contracts, CMS and the new RACs will visit each State in the "Summer 2008" group. The permanent RACs will vet all review topics through the CMS New Issue Review process, which will involve review by CMS clinical and coding experts, Medicare claims processing contractor reviewers, and/or through the RVC. The New Issue Review process concludes when the RAC posts a description of the new issue on its Web site (with appropriate links to coding guidelines, CMS manuals, local policies, etc.).

8. Conclusions

The RAC demonstration allows CMS and Medicare claims processing contractors to target actions aimed at preventing future improper payments. As a result, several claims processing edits have been installed to deny obvious errors, such as excessive units for Neulasta and colonoscopies. Further, provider education about RAC-identified problem areas is a critical component of the CMS strategy to prevent future improper payments. By educating providers about coding and medical necessity rules, providers can submit future claims correctly and thereby avoid being overpaid.

The RAC demonstration helped CMS plan the RAC permanent program. The results described in this report clearly indicate that the RAC demonstration was a useful resource for detecting and correcting past improper payments. CMS will evaluate the extent to which the RAC permanent program can protect the Medicare Trust Funds from future improper payments, thereby lowering the claims payment error rate and helping to preserve the Medicare Trust Funds for future generations.

The RAC demonstration was a cost-effective program, and the actions CMS is now taking, including initiatives to streamline the steps by which RAC improper payments are processed by the Medicare claims processing contractors, will result in an even more cost-effective program in the future.

> "It is critical that we ensure every dollar is spent wisely **so that the program is affordable for taxpayers and future generations of beneficiaries**."
>
> *– Kerry Weems, CMS Acting Administrator*

The RAC demonstration has proven to be successful in returning dollars to the Medicare Trust Funds and identifying underpayments for providers. The demonstration returned a significant amount of improper payments to the Medicare Trust Funds while limiting, to the extent possible, the burden on the provider community and the Medicare claims processing contractors. CMS views the RAC demonstration as an important financial management strategy that supports the President's goal of reducing improper payments and complements existing Medicare program safeguard activities. The RAC demonstration provided CMS with a new mechanism for detecting improper payments made in the past and has given CMS a valuable new tool for preventing overpayments in the future.

APPENDIXES

Appendix A
Medicare Modernization Act (Section 306)

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.
(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;

(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(**b) SCOPE AND DURATION** -
(1) SCOPE- The project shall cover at least 2 States that are among the States with-

(A) The highest per capita utilization rates of Medicare services, and

(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(**c) WAIVER** - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-
(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

Appendix B
Tax Relief and Health Care Act of 2006 (Section 302)

(h) USE OF RECOVERY AUDIT CONTRACTORS.—
(1) IN GENERAL.—Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under part A or B. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;
(B) from such amounts recovered, payment—
(i) shall be made on a contingent basis for collecting overpayments; and
(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and
(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) DISPOSITION OF REMAINING RECOVERIES.—The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under parts A and B.
(3) NATIONWIDE COVERAGE.—The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010.
(4) AUDIT AND RECOVERY PERIODS.—Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under part A or B—

(A) during such fiscal year; and
(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) WAIVER.—The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).
(6) QUALIFICATIONS OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

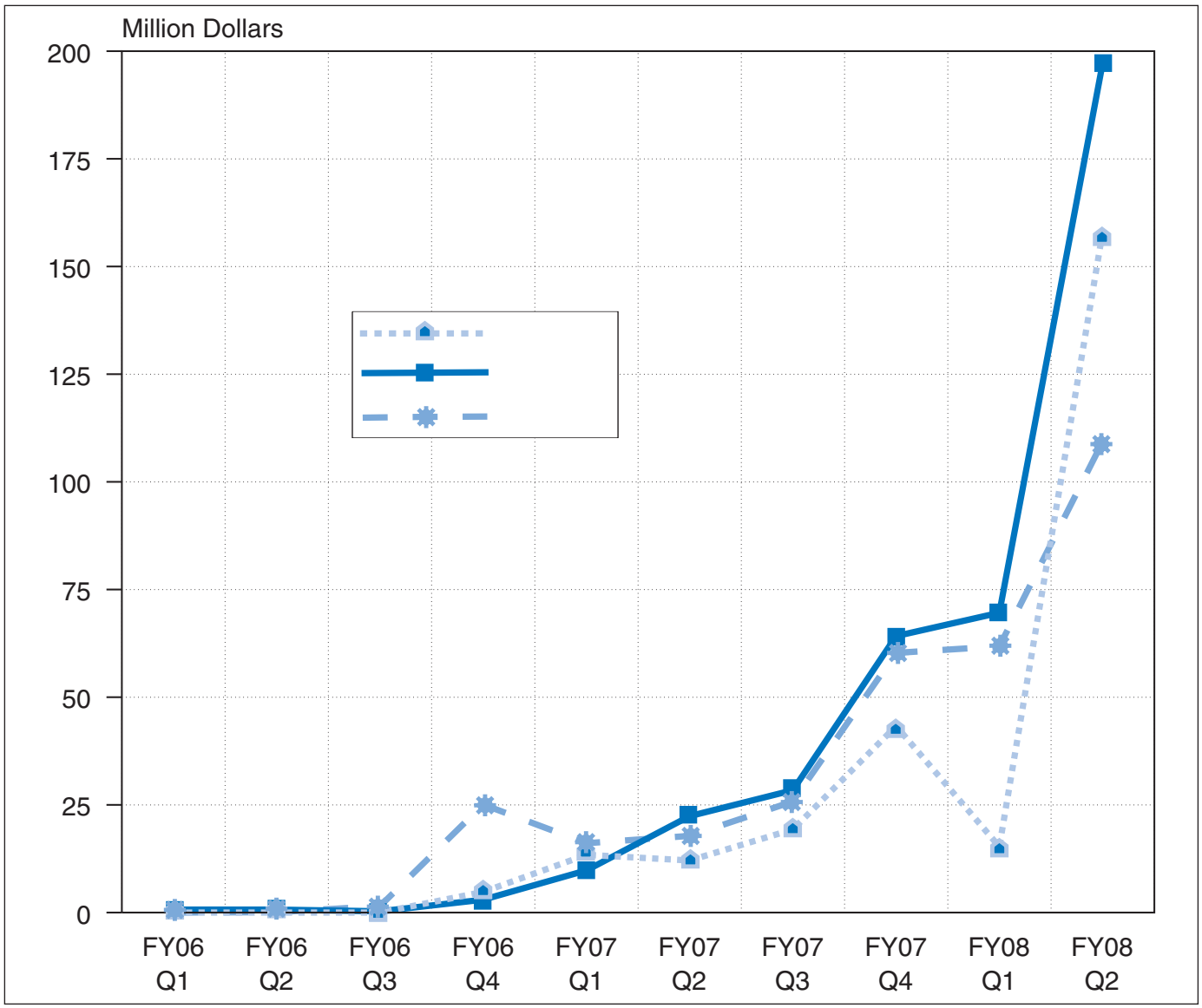
(B) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

(C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY.—In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

(7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.
(8) ANNUAL REPORT.—The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.

Appendix C
Improper Payments Corrected Over Time

Figure C1. Overpayments Collected by Fiscal Quarter Through 3/27/08, Individual Claim RACs



*The sharp decline in Connolly's FY08 Q1 collections is due to the Medicare claims processing contractor's transition to a new CMS-mandated computer system. Because all claims had to be manually adjusted during the transition, only a limited number of claims were adjusted in December before the end of the reporting period.
Source: RAC invoice files and RAC Data Warehouse.

Table C1. Improper Payments Corrected by Fiscal Year: Claim RACs Only

(Million Dollars)

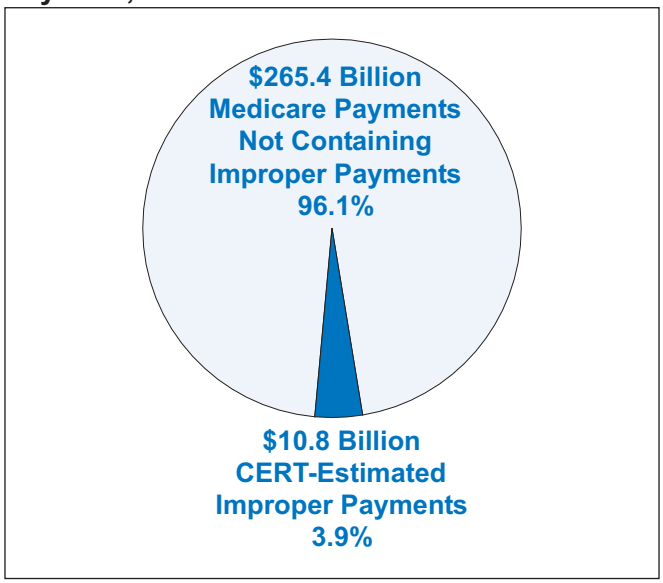
Period	Overpayments Collected	Underpayments Repaid	Total Improper Payments Corrected
FY 2006[a]	$ 36.2	$ <0.1	**$ 36.2**
FY 2007	$ 332.9	$ 14.1	**$ 347.0**
FY 2008, through 3/27/08	$ 610.9	$ 23.7	**$ 634.6**
Total	**$ 980.0**	**$ 37.8**	**$ 1,017.8**

[a]For this Evaluation Report, CMS lists all dollars actually collected and repaid that were invoiced between March 2005 and March 2008. This is in contrast to the reporting for the FY 2006 RAC Status Document, which was based on a combination of actual overpayments collected and underpayment *notification letters* that were sent to the providers and to the Medicare claims processing contractors during the fiscal year.

Source: RAC invoice files and RAC Data Warehouse.

Appendix D
CERT-Estimated Improper Payments in Medicare

Figure D1. Estimated Percentage of All Medicare Payments Containing an Improper Payment, FY 2007



Note: $276 billion in total dollars paid, less $10.8 billion in dollars improperly paid, gives the $265.4 billion total for payments that did not contain improper payments.
Source: FY 2007 Improper Medicare FFS Payments Report.

Appendix E
Overpayments Collected by Error Type and Provider Type

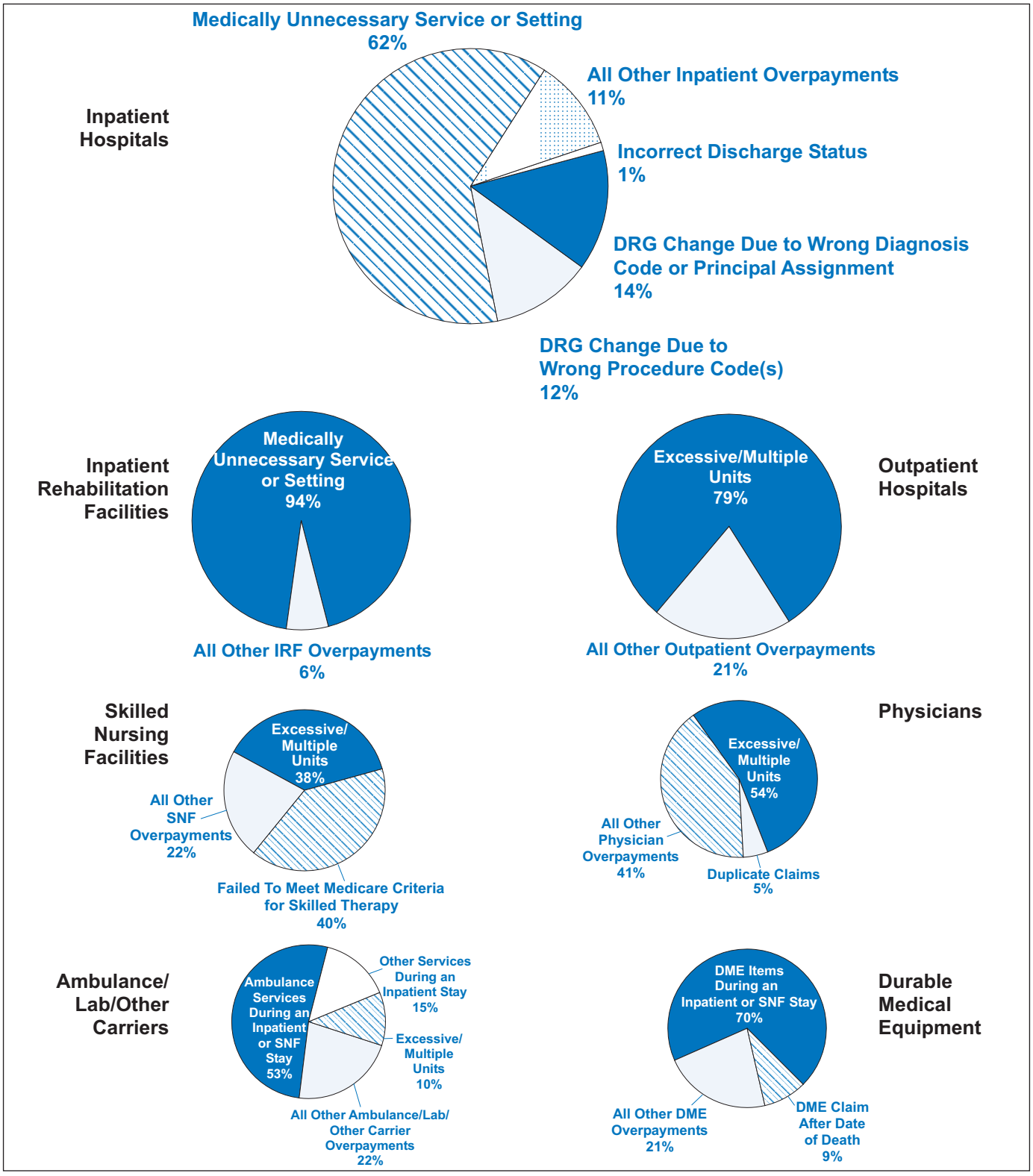
Table E1. Overpayments Collected by Error and Provider Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only
(Percent of Total)

Error Type	Inpatient Hospital	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Outpatient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equipment	Total Overpayments Collected
Medically Unnecessary	34.50	5.63	0.26	0.47	0.00	0.00	0.00	40.86
Incorrectly Coded	30.48	0.00	0.62	2.44	1.05	0.06	0.00	34.66
No/Insufficient Documentation	6.63	0.44	0.48	0.11	0.00	0.00	0.09	7.76
Other	12.57	0.00	0.41	1.22	1.44	0.45	0.63	16.72
Total	**84.19**	**6.07**	**1.76**	**4.25**	**2.50**	**0.51**	**0.72**	**100.00**

Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.

Appendix F
Audit Areas and Top Errors by Provider Type

Figure F1. Audit Areas and Top Errors by Provider Type, Net of Appeals: Cumulative Through 3/27/08, Claim RACs Only (Percent of Overpayment Amount)



Source: Self-reported by the Claim RACs.

Appendix G
Top Services With Overpayments

Table G1. Top Services With RAC-Initiated Overpayment Collections (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal (Million Dollars)	Number of Claims With Overpayments Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA
Inpatient Rehabilitation Facility	Services following joint replacement surgery (medically unnecessary)	37.0	3,253	CA
	Services for miscellaneous conditions (medically unnecessary)	17.4	1,235	CA
Outpatient Hospital	Neulasta (medically unnecessary)	6.5	558	NY, FL
	Speech-language pathology services (medically unnecessary)	3.2	24,991	NY, CA
	Infusion services (medically unnecessary)	2.3	19,271	CA
Skilled Nursing Facility	Physical therapy and occupational therapy (medically unnecessary)	6.8	77,911	CA
	Speech-language pathology services (medically unnecessary)	1.6	3,012	CA
Physician	Pharmaceutical injectables (incorrect coding)	5.8	18,930	NY, CA
	Neulasta (medically unnecessary)	3.0	56	NY
	Vestibular function testing (other error type)	1.4	13,805	FL
	Duplicate claims (other error type)	1.0	11,165	CA
Lab/Ambulance/Other	Ambulance services during a hospital inpatient stay (other error type)	2.9	13,589	FL, CA
Durable Medical Equipment	Items during a hospital inpatient stay or SNF stay (other error type)	4.8	38,257	NY, FL, CA

Source: Self-reported by the Claim RACs.

Appendix H
Top Services With Underpayments

Table H1. Top Services With Underpayments Refunded to Providers: Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Refunded	Number of Claims With Underpayments	Location of Problem
Inpatient Hospital	Discharge status (incorrectly coded)	$19.6 million	8,584	FL, CA
	Wound debridement (incorrectly coded)	$ 3.0 million	622	NY, FL, CA
	Operating room procedures unrelated to principal diagnosis (incorrectly coded)	$ 1.1 million	181	FL, CA
	Respiratory system procedures (incorrectly coded)	$ 643,255	133	NY, CA
	Surgical procedures with an incorrect DRG (incorrectly coded)	$ 491,248	62	NY
	Circulatory system diagnosis (incorrectly coded)	$ 323,087	78	FL, CA
	Bowel procedure (incorrectly coded)	$ 250,548	25	CA
	Respiratory infections and inflammation (incorrectly coded)	$ 240,656	46	CA
	Kidney and urinary tract Infections (incorrectly coded)	$ 239,633	66	CA
	Pneumonia (incorrectly coded)	$ 239,071	74	CA
Outpatient Hospital	Drug codes (incorrectly coded)	$ 1.1 million	1,084	NY
	Oxaliplatin (incorrectly coded)	$ 614,269	346	NY
	Darbopoetin (incorrectly coded)	$ 260,176	726	NY
Durable Medical Equipment	Initial item/service was paid so accompanying item/service should be paid (incorrectly coded)	$ 140,847	602	FL

Source: Self-reported by the Claim RACs.

Appendix I
Average Overpayment Amounts

Table I1. Average Overpayment Amounts: Cumulative Through 3/27/08, Claim RACS Only

Type of Provider	Average Overpayment Amount					
	Connolly		HDI		PRG	
	Per Claim[a]	Per Provider per Year	Per Claim[a]	Per Provider per Year	Per Claim[a]	Per Provider per Year
Inpatient hospital/IRF/SNF	$ 12,157	$ 483,774	$ 3,917	$ 118,834	$ 6,309	$ 850,502
Outpatient hospital	$ 327	$ 10,398	$ 567	$ 6,465	$ 398	$ 24,640
Physician	$ 140	$ 372	$ 103	$ 1,441	$ 214	$ 602
Ambulance/Lab/Other	—	—	$ 88	$ 429	$ 231	$ 2,631
Durable medical equipment	$ 174	$ 1,361	$ 466	$ 1,039	$ 126	$ 1,943

[a]Average overpayment amount per claim based on number of overpayments collected from 10/1/06 to 3/27/08, where the collection amount was greater than $0.
Source: Self-reported by the RACs.

Appendix J
Medical Record "Hit Rates"

Thirty-three percent of medical record reviews resulted in an overpayment finding. RACs attempted to target their medical record request letters to those claims most likely to contain improper payments, in an effort to minimize the burden on providers and maximize the return on investment for RACs. Out of all of the medical records reviewed from the inception of the demonstration through March 27, 2008, 33 percent resulted in overpayment collections. This ratio—number of medical record requests to number of claims with improper payment findings—is also known as a medical record "hit rate." Table J1 shows that all the RACs' medical record hit rates were similar, ranging from 29 percent to 37 percent, and quite similar to the hit rate (31%) experienced by Medicare claims processing contractors nationwide from FY 2005 through FY 2007.

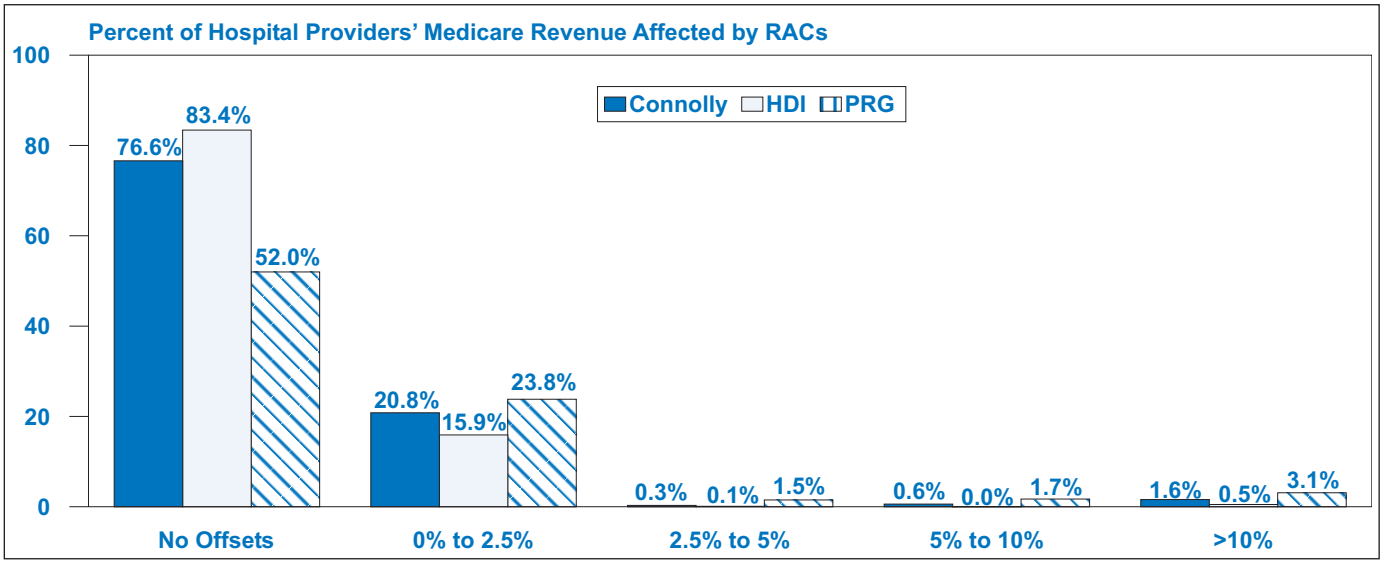
Table J1. Cumulative Claim Counts for Complex Reviews Through 3/27/08, Claim RACs Only

Type of Claim	Number of Claims			
	Connolly	HDI	PRG	All RACs
Claims where the RAC conducted a complex review	57,228	198,243	234,288	**489,759**
Claims where the RAC collected an overpayment following a complex review	20,049	72,965	67,897	**160,911**
Percentage of complex reviews that resulted in an overpayment collection	35%	37%	29%	**33%**

Source: Self-reported by the Claim RACs.

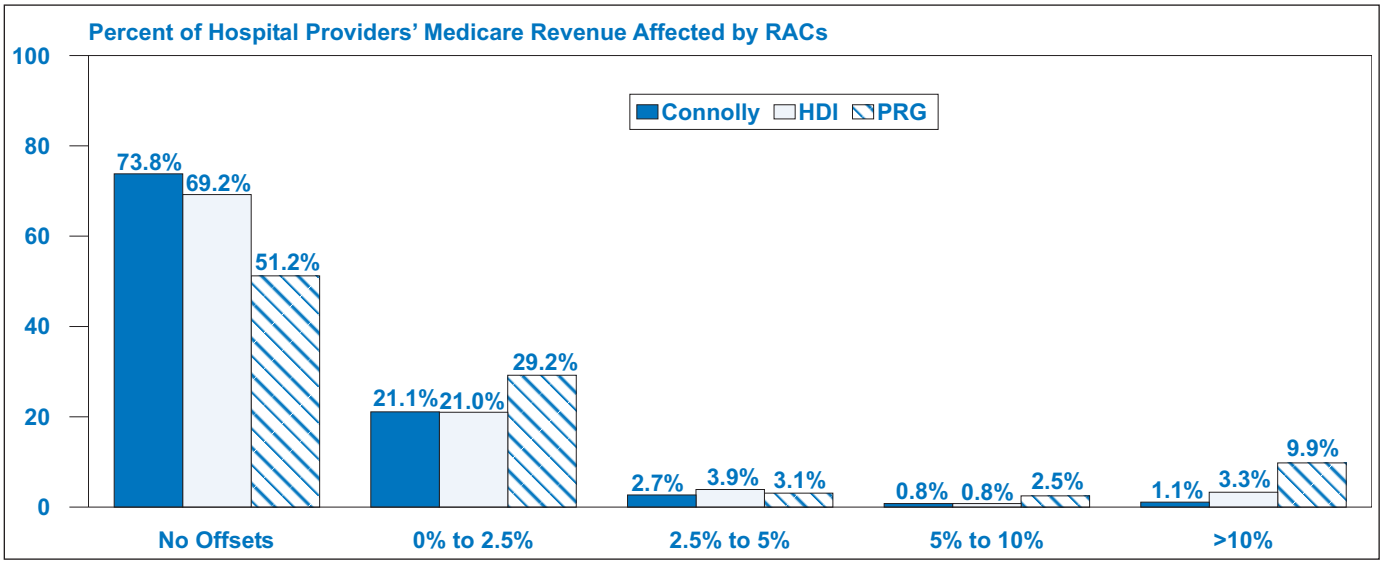
Appendix K
Financial Impact on Hospital Providers

Figure K1. Financial Impacts on Hospital Providers: Fiscal Year 2006, Claim RACs Only



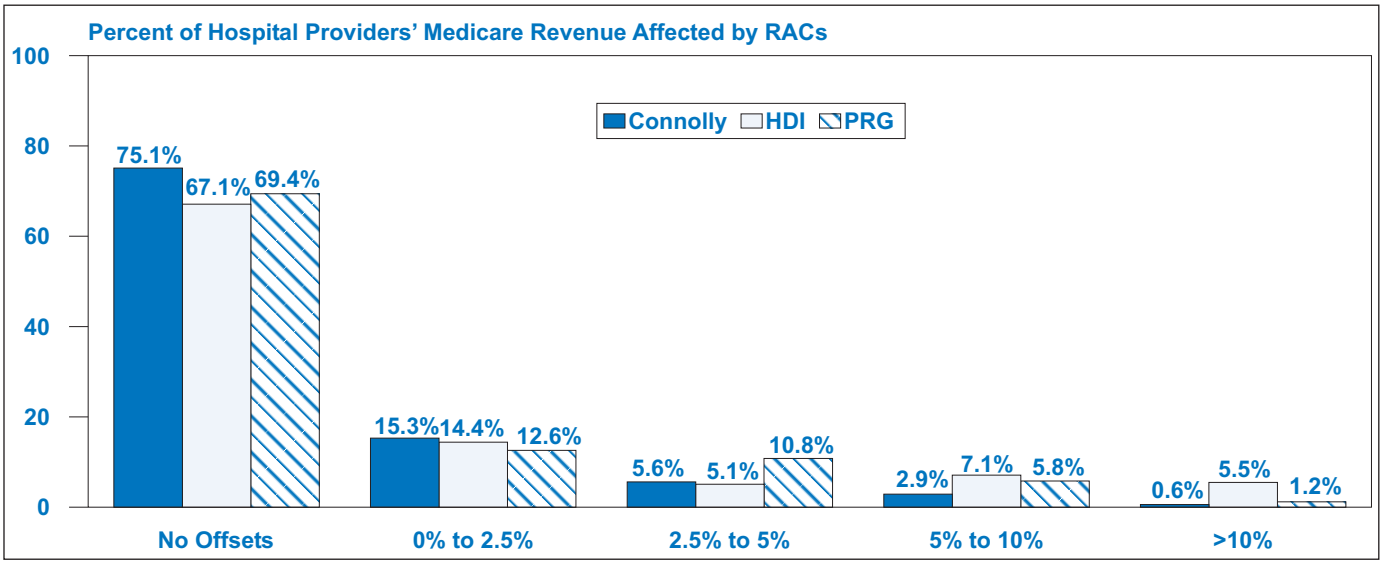
Source: Self-reported by the RACs.

Figure K2. Financial Impacts on Hospital Providers: Fiscal Year 2007, Claim RACs Only



Source: Self-reported by the RACs.

Figure K3. Financial Impacts on Hospital Providers: Fiscal Year 2008, Claim RACs Only



Source: Self-reported by the RACs.

Appendix L
Provider Appeals

Table L1. Provider Appeals of RAC-Initiated Overpayments: Cumulative Through 3/27/08, Claim RACs Only

Type	Claim RAC	Number of Claims with Overpayment Determinations	Number of Claims Where Provider Appealed				Claims Appealed by Providers at Any Level		Appealed Claims with Decisions in Provider's Favor		Percentage of Overpayment Determinations Overturned on Appeal
			FI	QIC	ALJ	DAB	Number	Percent	Number	Percent	
Part A	Connolly	78,698	3,796	457	7	0	4,260	5.4%	2,195	51.5%	2.8%
	HDI	104,394	11,545	695	0	0	12,240	11.7%	4,207	34.4%	4.0%
	PRG	91,860	10,763	1,715	301	9	12,788	13.9%	1,129	8.8%	1.2%
	Subtotal	*274,952*	*26,104*	*2,867*	*308*	*9*	*29,288*	*10.7%*	*7,531*	*25.7%*	*2.7%*
Part B	Connolly	31,937	2,006	8	0	0	2,014	6.3%	1,380	68.5%	4.3%
	HDI	134,811	29,672	16	0	0	29,688	22.0%	12,912	43.5%	9.6%
	PRG	83,433	11,099	1,022	155	0	12,276	14.7%	2,553	20.8%	3.1%
	Subtotal	*250,181*	*42,777*	*1,046*	*155*	*0*	*43,978*	*17.6%*	*16,845*	*38.3%*	*6.7%*
Parts A and B Combined	Connolly	110,635	5,802	465	7	0	6,274	5.7%	3,575	57.0%	3.2%
	HDI	239,205	41,217	711	0	0	41,928	17.5%	17,119	40.8%	7.2%
	PRG	175,293	21,862	2,737	456	9	25,064	14.3%	3,682	14.7%	2.1%
Total	**All RACs**	**525,133**	**68,881**	**3,913**	**463**	**9**	**73,266**	**14.0%**	**24,376**	**33.3%**	**4.6%**

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some appeals pending in the appeals process. This is because some Medicare claims processing contractors cannot distinguish between appeals of RAC determinations and appeals of other contractor determinations. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 3/27/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

Table L2. Dollars Overturned on Appeal: Cumulative Through 3/27/08, Claim RACs Only
(Million Dollars)

Overpayments collected	$ 980.0
Amount overturned on appeal	$ 46.0
Percentage of overpayment collections overturned on appeal	4.7%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

Appendix M
Summary of Work Performed by Econometrica, Inc. Under the RAC Demonstration Project

ECONOMETRICA, INC.

May 19, 2008

Wayne Slaughter, Ph.D.
RAC Evaluation Contractor Project Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Dr. Slaughter:

Since the Recovery Audit Contractor (RAC) demonstration project has concluded, this letter summarizes the tasks that Econometrica has performed under the project and is currently performing in support of the transition to the permanent RAC program.

Recently, at the request of CMS, we have supported the agency in the production of the provisional evaluation report on the RAC demonstration project. Toward this end, we verified certain summary data included in this report and are currently in the process of documenting the results of that effort. We also supported CMS in developing a format for the report as well as in making edits to the content of the report as requested by CMS staff.

A second data verification effort we have been performing over the past several months has been in support of CMS' quality assurance of RAC data processes. This work has involved assessing the completeness of certain data that are routinely entered into the RAC data warehouse and reporting on the results. The process includes reconciling the number of claims and their associated dollar-error amounts with invoice data and transaction data (CMS receives invoice data from the Claim RACs and transaction data from the Medicare claims processing contractors). The purpose of the reconciliation is to ensure that the number of improper claims and amounts found to be in error that are archived in the data warehouse match the improper claims data CMS receives from other sources. To date, we have reported the results for data matched through December 2007, and are now finalizing the reconciliation of data submitted through March 2008. Our ongoing reconciliation work will continue to support CMS in its oversight of the Claim RACs under the permanent program and in developing an archive of reliable program data stored in the data warehouse.

As part of this activity, we have also developed a framework for reporting on RAC collection and other performance activities on a monthly or quarterly basis. This framework will be a useful

tool for monitoring key indicators on performance by the RACs under the permanent program and will support preparation of future annual reports. We have submitted a draft outline of such a report to CMS for review. Once we complete our data reconciliation work and finalize the report format, we will be able to develop annual and/or quarterly reports going forward, as data under the permanent program are collected.

Another task we have been performing is sampling for the RAC validation effort. To this end, we supported the development of an initial sampling approach for the validation work under the demonstration project, which involved drawing monthly stratified random samples of RAC-reviewed claims that had been identified with an overpayment or underpayment. To help facilitate expansion of quality assurance under the future RAC program, we have developed a sampling plan methodology for conducting the validation work under the permanent program. The sampling plan includes the sample frame, the universe of claims from which we would sample, how the sample claims would be drawn, and how the data are to be analyzed. To date, we have provided random samples of claims data for the months of September 2007 through February 2008. We expect to continue to perform this work for the validation effort under the permanent RAC program.

Another task we performed was a survey of providers' views toward the RAC project. Under the supervision of Econometrica, the Gallup Organization conducted an independent survey of providers' perceptions of the RAC program in 2007. Using computerized telephone interviews, the Gallup Organization contacted a sample of providers between May and July 2007. These providers had received either a medical record request letter or an overpayment recoupment from a RAC at least once in the year prior to the survey. We submitted the final report on the survey results in September 2007. The survey established an important baseline for assessing provider satisfaction with the RAC demonstration. CMS may wish to conduct follow-on surveys as part of the future expansion of the RAC program.

Another component of our work has been the development and deployment of the OFM Efficiency Tool software, which was rolled out to CMS in September 2007. The idea was to have CMS work with the software as part of a testing phase. We are now in the process of specifying changes to make the software more user-friendly and to develop a strategy for implementing this tool to support CMS in its ongoing administration of the RAC program.

As part of our future program-integrity work in analyzing payment error findings, we are working to develop a methodological approach that would help CMS identify trends in claims with problematic errors under the permanent RAC program. We are in the initial stage of this work, but the goal is to develop a predictive approach that would flag claims with probable improper payments. We plan to use data from the RAC data warehouse to develop this methodology.

The tasks described above reflect, to the best of our knowledge, CMS' priorities, which have been articulated through numerous discussions over the course of the demonstration. Should you have any questions or require further information, please feel free to contact me at (301) 657-8311.

Sincerely,

Econometrica, Inc.

Cyrus Bagherpour
President/CEO

cc: Gerald Walters
George Mills
Edward Berends
Melanie Combs
Craig Gillespie

Appendix N
Summary of RAC Validation Work Performed by AdvanceMed

advancemed Corporation

April 21, 2008

Melanie Combs-Dyer, Recovery Audit Contractor (RAC) Technical Advisor
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Combs-Dyer:

This letter serves to summarize the work that AdvanceMed performed for the Recovery Audit Contractor (RAC) demonstration program as the RAC Validation Contractor (RVC).

In September 2007 CMS tasked AdvanceMed with assessing the accuracy of RAC-identified overpayment determinations. At CMS' request, our first task involved reviewing a sample of Inpatient Rehabilitation Facility (IRF) claims on which a RAC had collected overpayments.

AdvanceMed then began reviewing a number of "new issues" that the RAC wished to pursue for potential overpayments. Each RAC would send a small sample of claims and/or medical records for each new issue CMS wished to have validated before allowing the RAC to proceed with a larger-scale review. We would then issue a report with claim count and dollar amount accuracy rates, as well as a brief rationale for each new issue.

AdvanceMed also reviewed a random sample of claims on which the RACs had previously identified and collected overpayments. We issued a monthly accuracy report for each RAC and are developing the cumulative accuracy report. These reports also included claim count and dollar amount accuracy rates, along with more detailed explanations.

Should you have any questions or require further information, please let me know.

Sincerely,

John Simpson
CERT Program Director

1530 East Parham Road
Richmond, VA 23228
804.264.1778 Fax 804.264.8191

Appendix O
Re-Review of IRF "Wrong Setting" Claims

The vast majority of improper payments collected from inpatient rehabilitation facilities (IRFs) were due to the "wrong setting" issue (Figure F1). Over the life of the demonstration, PRG denied 5,237 claims on the basis that the beneficiary did not require the intensive rehabilitation services provided in an IRF, and that the therapy was appropriate in a less intensive setting, such as an SNF. The California Hospital Association was concerned with PRG's interpretation of the CMS medical necessity criteria for IRF services (HCFA Ruling 85-2 and CMS Benefit Policy Manual 100-2, Chapter 1, Section 110).

In September 2007, CMS instituted a "pause" in all IRF reviews to allow for an independent review of a sample of denied claims and further discussion with other Medicare contractors on IRF medical record review. It became clear that, with respect to IRF reviews in California, CMS contractors were not consistently applying Medicare policy for IRF services. CMS provided training to contractors reviewing IRF claims in California,[1] and then instructed PRG to re-review all previously denied IRF claims using the medical review methodology described in the training. PRG was then instructed to repay providers for any cases it had reversed.

Table O1 shows data on PRG's IRF re-review, and Table E1 in Appendix E shows that collections resulting from those reviews represented only 6 percent of all collections.

Table O1. PRG IRF Re-reviews

Original number of claims with notification letters sent to providers	5,237
Number of claims reversed by PRG	1,454
Dollars refunded to IRF providers	$14.0 million

Source: PRG-Schultz.

[1]The contractors included the RAC, FI, QIC (second-level appeal contractors), and the CERT Contractor/RAC Validation Contractor.

Appendix P
Service-Specific Examples of Overpayments Identified by the RACs

Table P1. Excisional Debridements (Complex Review, Incorrect Coding)

Claim Facts

- The hospital coder assigned a procedure code of 86.22.
- In the medical record, the physician writes "debridement was performed."
- Coding Clinic 1991Q3 states "Unless the attending physician documents in the medical record that an excisional debridement was performed (definite cutting away of tissue, not the minor scissors removal of loose fragments), debridement of the skin should be coded to 86.26, non excisional debridement of skin… Any debridement of the skin that does not meet the criteria noted above or is described in the medical record as debridement and no other information is available should be coded as 82.26."
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly correctly coded procedure and the payment amount for the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for excisional debridement.
- Medicare claims processing contractors can remind hospitals about the importance of following the coding clinic guidelines when submitting claims for excisional debridement.

Table P2. Inpatient Rehabilitation (Complex Review, Medically Unnecessary Setting)

Claim Facts

- An Inpatient Rehabilitation Facility (IRF) submitted a claim for inpatient therapy following a single knee replacement
- Medical record indicated that although the beneficiary required therapy, the beneficiary's condition did not meet Medicare's medical necessity criteria for IRF care (HCFA Ruling 85-2 and Medicare Benefit Policy Manual Section 110)
- The RAC determined that the service was MEDICALLY UNNECESSARY for the inpatient setting and issued a repayment request letter for the entire claim. The provider may resubmit the claim for ancillary services that would have been covered had the services been properly provided in an outpatient setting.

Corrective Actions

- Inpatient Rehabilitation Facilities can be more careful when admitting Medicare beneficiaries for inpatient therapy to make sure that the Medicare medical necessity criteria are met.
- Medicare claims processing contractors can remind hospitals about the medical necessity criteria in HCFA Ruling 85-2 and the Medicare Benefit Policy Manual section 110.

Table P3. Wrong Principal Diagnosis (Complex Review, Incorrect Coding)

Claim Facts

- Principal diagnosis on claim did not match the principal diagnosis in the medical record.
- Example: respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis.
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded services and the amount for the correctly coded services.
- Most common DRGs with this problem:
  - DRG 475 (respiratory system diagoses)
  - DRG 468 (extensive OR procedure unrelated to principal diagnosis)

Corrective Actions

- Hospitals can be more careful when submitting claims for DRG 475 and 468 to ensure that they choose the correct diagnosis to list as principal.
- Medicare claims processing contractors can remind hospitals about the importance of listing the correct principal diagnosis on the claim, especially when billing for DRG 468 and 475.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table P4. Wrong Diagnosis Code (Complex Review, Incorrect Coding)

Claim Facts

- Hospital reported a principal diagnosis of 03.89 (septicemia)
- Medical record shows diagnosis of urosepsis, not septicemia or sepsis; Blood cultures were negative
- Did not meet the coding guidelines for "septicemia." Changing the diagnosis code to urinary tract infection (UTI) caused the claim to group to a lower DRG
- The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure.

Corrective Actions

- Hospitals can be more careful when submitting claims for septicemia
- Medicare claims processing contractors can remind hospitals about the importance of listing an accurate principal diagnosis for beneficiaries with a UTI.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also to the American Hospital Association's definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

Table P5. Neulasta (Automated Review, Medically Unnecessary Services)

Claim Facts

- In the past, the billing code for the drug Neulasta (Pegfilgrastim) indicated that providers should bill 1 unit for each milligram of drug delivered
- Several years ago, CMS changed the definition of the billing code to indicate that providers should bill 1 unit for each vial of drug delivered.
- The hospital billed for 6 units of Neulasta
- The RAC determined that 5 units of service were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for 5 unnecessary vials.

Corrective Actions

- Transmittal 949 clarifies billing for Neulasta. The transmittal can be found at: http://www.cms.hhs.gov/transmittals/downloads/R949CP.pdf.
- Hospitals can be more careful when submitting claims for Neulasta. Hospitals can program their billing computers carefully when CMS changes the definition of a code.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim, especially when changes to the code definition occur.

Table P6. Colonoscopy (Automated Review, Medically Unnecessary Services)

Claim Facts

- The hospital billed for multiple colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) for the same beneficiary the same day.
- Beneficiaries never need more than one colonoscopy per day.
- The RAC determined that the excessive services were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for the unnecessary services.

Corrective Actions

- Hospitals can be more careful when submitting claims for colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) to ensure they do not bill for more than one per day per beneficiary.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Table P7. Outpatient Hospital Speech Therapy (Automated Review, Medically Unnecessary Services)

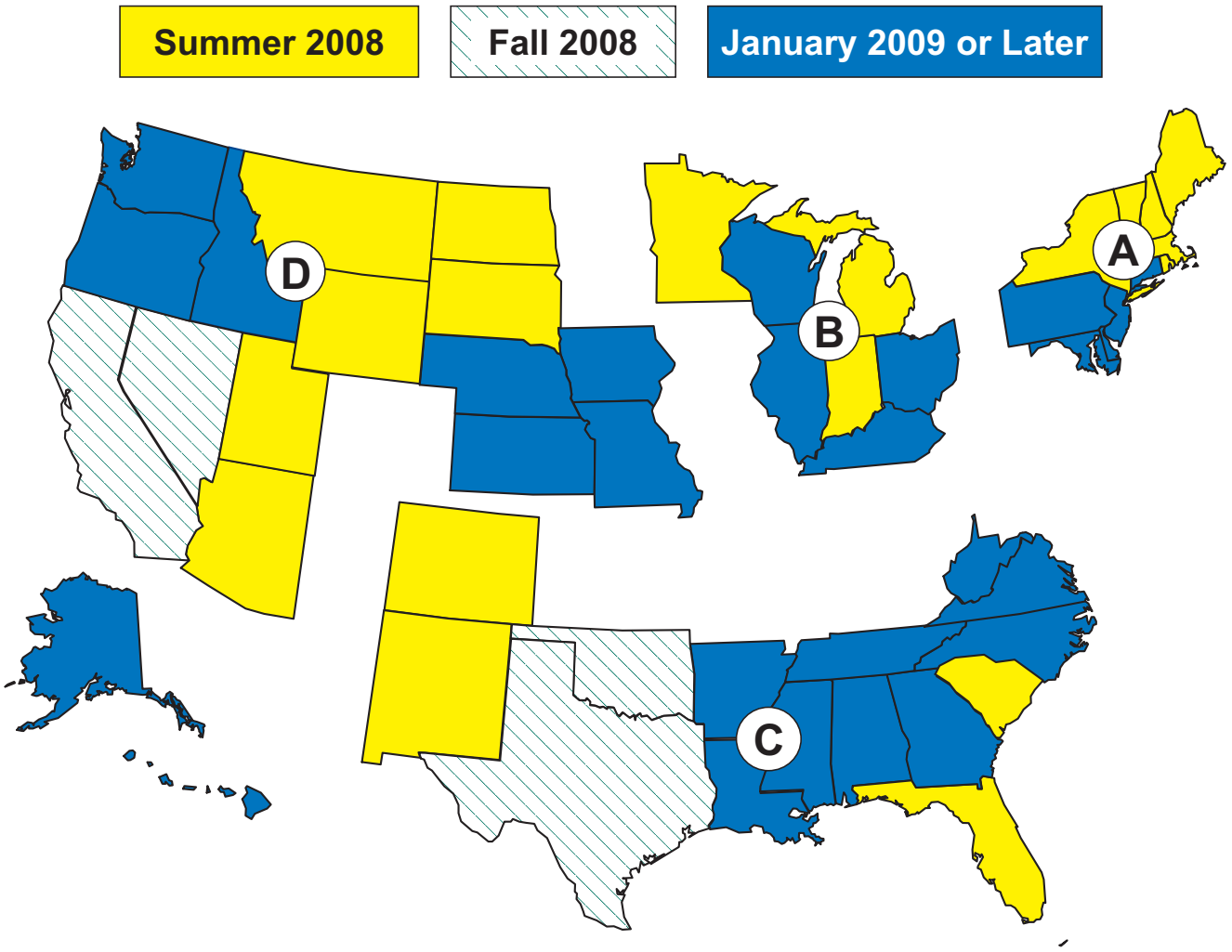
Claim Facts

- The outpatient hospital billed for each 15 minutes of therapy.
- The code definition specifies that the code is per session, not per 15 minutes.
- The units billed exceeded the approved numberof sessions per day.
- The RAC determined that the excessive services billed were MEDICALLY UNNECESSARY and issued a repayment request letter for the payment amount for the unnecessary services.

Corrective Actions

- CMS Claims Processing Manual 100-4, Chapter 5, Section 20.2 clarifies billing for untimed codes. The section be found at: http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf
- Hospitals can be more careful when submitting claims for therapy services.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of "units of service" on a claim.

Appendix Q
RAC Expansion Schedule



Appendix R
Key Dates

Table R1. Key Dates

Activity	Date
Congress passes Section 306 of the Medicare Modernization Act requiring the use of RACs	December 2003
CMS announces RAC demonstration	January 2005
CMS releases Requests for Proposals (RFP) for NY, FL, and CA	January 2005
CMS signs contracts for Claim RACs in NY, FL, and CA and MSP RACs in FL and CA	March 28, 2005
RACs begin releasing significant overpayment notifications	January 2006
CMS signs contract for MSP RAC in NY	February 23, 2006
FY 2006 Status Document released	November 16, 2006
Congress passes Section 302 of the Health Care Act of 2006, which requires the RAC program be made permanent and implemented nationally by 2010	December 2006
CMS releases Request for Information and draft Statements of Work for 4 permanent RACs	March 16, 2007
CMS signs contract for demonstration Claim RACs to expand to MA, SC, and AZ	June 2007
RFP for RAC permanent program released	October 19, 2007
Proposals due from bidders wishing to become a permanent RAC	December 17, 2007
FY 2007 Status Document released	February 28, 2008
RAC demonstration ends	March 27, 2008
Release Demonstration Evaluation Report	June 2008 (anticipated)
Award national RAC contracts	TBD
Begin provider outreach in summer 2008 RAC States	TBD

Appendix S
Total Claim Counts

Table S1. Total Claim Counts by Provider Type: Cumulative Through 3/27/08

RAC	Provider Type					All Claims Given to RAC by CMS
	Inpatient Hospital/ Skilled Nursing Facility	Outpatient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equipment	
Number of claims						
Connolly	9,448,001	75,848,174	306,148,137	28,346,109	18,296,149	**438,086,570**
HDI	6,595,541	40,272,602	322,008,507	75,020,832	31,616,797	**475,514,279**
PRG	7,018,047	30,321,819	164,230,881	40,556,690	12,211,867	**254,339,304**
All RACs	**23,061,589**	**146,442,595**	**792,387,525**	**143,923,631**	**62,124,813**	**1,167,940,153**
Dollar value of claims						
Connolly	78,560,668,167	15,359,217,915	29,310,787,145	2,121,894,795	2,416,275,452	**127,768,843,473**
HDI	45,118,196,206	9,538,690,860	33,718,039,221	6,747,450,982	4,848,726,851	**99,971,104,120**
PRG	57,720,976,823	7,516,391,317	16,146,066,099	5,612,029,966	2,251,081,856	**89,246,546,061**
All RACs	**181,399,841,195**	**32,414,300,092**	**79,174,892,465**	**14,481,375,743**	**9,516,084,158**	**316,986,493,653**

Source: Self-reported by the RACs.

The Medicare Recovery Audit Contractor (RAC) Program:

Update

to the Evaluation of the

3-Year Demonstration

September 2008

Purpose

The purpose of this report is to evaluate the RAC demonstration and to share with all interested parties information about the demonstration. This September revision serves to update information reported in the Evaluation report released in July 2008, which included information through March 27, 2008. This report includes updated appeals statistics through June 30, 2008. This report includes information primarily on Claim RACs only; however some tables include data on both Claim and MSP RACs. CMS will continue to update this information on a regular basis through the fall of 2008. A full update to the Demonstration Evaluation Report, including updated cost and collection information, will be released in late 2008 or early 2009.

Background

In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program. Congress gave CMS the authority to pay each RAC on a contingency fee basis, which is a percentage of the improper payments corrected by the RACs.

CMS designed the RAC Program to:

1) Detect and correct *past* improper payments in the Medicare FFS program; and

2) Provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the Medicare FFS claims payment error rate.

CMS held a full and open competition to competitively select three RACs for the demonstration. Initially each RAC was given a single State jurisdiction. California, Florida, and New York were selected for the demonstration because they are the largest States in terms of Medicare utilization. PRG-Schultz (PRG) was awarded the contract for California, HealthDataInsights (HDI) was awarded the contract for Florida, and Connolly Consulting was awarded the contract for New York. Each jurisdiction was expanded by one State in the summer of 2007 to include Arizona, South Carolina, and Massachusetts.

Results of the RAC Demonstration

RACs succeeded in correcting more than $1.03 billion of Medicare improper payments (see Table SU4). Approximately 96 percent of these improper payments were overpayments collected from providers, while the remaining 4 percent were underpayments repaid to providers.

Table SU4: Improper Payments Corrected by the RAC Demonstration: Cumulative through 3/27/08, Both Claim RACs and MSP RACs (Million Dollars)

RAC	Overpayments Collected	Underpayments Repaid	Total Improper Payments Corrected
Connolly	$266.1	$4.3	$270.4
HDI	$396.1	$20.8	$416.9
PRG	$317.8	$12.7	$330.5
Claim RAC Subtotal	***$980.0***	***$37.8***	***$1,017.8***
HMS	$1.3	$0.0	$1.3
DCS	$11.4	$0.0	$11.4
MSP RAC Subtotal	***$12.7***	***$0.0***	***$12.7***
Grand Total	**$992.7**	**$37.8**	**$1,030.5**

Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury Deposit Slips.

Updated Appeals of RAC Determinations

From the inception of the RAC demonstration through June 30, 2008, providers chose to appeal only 19.6 percent (102,705) of the RAC determinations. Overall, the data indicate that of all the RAC overpayments determinations (525,133), only 6.8 percent (35,819) were overturned on appeal (see Table SU7). Appendix SUL includes more detailed data on appeals.

Table SU7: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, Claim RACs Only

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	102,705
Number of claims with appeal decisions in provider's favor	35,819
Percentage of appealed claims with a decision in provider's favor	34.9%
Percentage of claims overturned on appeal	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

In addition to the data in Table SU7, as of June 30, 2008, there are an additional 1,607 claims (valued at $12.0 million) pending at the ALJ – the third level of appeals (see Table SU9). At this time, CMS is not able to determine the number of appeals pending at the first level. CMS believes that the majority of first-level appeals of RAC determinations should have been filed by July 1, 2008. For this reason, the tables in this report will be updated on a regular basis through the fall of 2008.

Table SU9: Pending Appeals as of 6/30/08

Level of Pending Appeal	Number of Claims	Value of Claims (Million Dollars)
Pending at ALJ	1,607	$12.0

Source: Administrative Qualified Independent Contractor (AdQIC)

Preventing Future Improper Payments

Future improper payments can be avoided by analyzing the RACs' service-specific findings. CMS can use this information to implement more provider education and outreach activities or establishing new system edits, with the goal of preventing future improper payments. Hospitals and other health care providers can use this information to help ensure that they are submitting correctly coded claims for services that meet Medicare's coding and medical necessity policies.

Conclusion

The RAC demonstration was an important tool in helping CMS prepare for and shape the RAC permanent program. This preparation led to the incorporation of several important components of the RAC permanent program, including building cooperative relationships with Medicare claims processing contractors, fraud fighters, the Department of Justice, and appeals entities; contracting with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations; limiting the claim review look-back period to three years; requiring each RAC to hire a medical director; and conducting significant outreach to providers. CMS will expand the RAC program gradually.

Appendix L

Provider Appeals

Table SUL1: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, Claim RACs only, Part A claims only

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider (all levels)	% favorable to provider (all levels)	% of all claims overturned on appeal
Connolly	78,698	5,207	654	29	0	5,890	7.5%	3,214	54.6%	4.1%
HDI	104,394	16,582	2,098	47	0	18,727	17.9%	6,325	33.8%	6.1%
PRG	91,860	11,849	2,298	339	18	14,504	15.8%	1,091[1]	7.5%	1.2%
All RACs	274,952	33,638	5,050	415	18	39,121	14.2%	10,630	27.2%	3.9%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 6/30/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

Table SUL2: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, Claim RACs only, Part B claims only

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider (all levels)	% favorable to provider (all levels)	% of all claims overturned on appeal
Connolly	31,937	2,226	9	0	0	2,235	7.0%	1,447	64.7%	4.5%
HDI	134,811	47,216	20	0	0	47,236	35.0%	21,232	45.0%	15.8%
PRG	83,433	12,566	1,353	194	0	14,113	16.9%	2,510[2]	17.8%	3.0%
All RACs	250,181	62,008	1,382	194	0	63,584	25.4%	25,189	39.6%	10.1%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing

[1] Due to a number of duplicate appeals that were included in the previously released RAC Demonstration Evaluation Report, the number of appeal decisions in providers' favors for PRG has decreased.

[2] Due to a number of duplicate appeals that were included in the previously released RAC Demonstration Evaluation Report, the number of appeal decisions in providers' favors for PRG has decreased.

contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 6/30/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

Table SUL3: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 6/30/08, Claim RACs only, Parts A and B claims combined

Claim RAC	Claims with Overpayment Determinations	# appealed to FI	# appealed to QIC	# appealed to ALJ	# appealed to DAB	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	110,635	7,433	663	29	0	8,125	7.3%	4,661	57.4%	4.2%
HDI	239,205	63,798	2,118	47	0	65,963	27.6%	27,557	41.8%	11.5%
PRG	175,293	24,415	3,651	533	18	28,617	16.3%	3,601[3]	12.6%	2.1%
All RACs	525,133	95,646	6,432	609	18	102,705	19.6%	35,819	34.9%	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 6/30/08. Any QIC or ALJ appeals reported to the Medicare claims processing contractors after that date are not included in these statistics.

[3] Due to a number of duplicate appeals that were included in the previously released RAC Demonstration Evaluation Report, the number of appeal decisions in providers' favors for PRG has decreased.

MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: N/A
MLN Matters Number: SE0469
Related CR Release Date: N/A

MMA – The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that will begin during the first part of 2005 and last for three years.

Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and Durable Medical Equipment Regional Carriers (DMERCs)).

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in 1) identifying underpayments and overpayments, and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

A small percentage of claims (< 5 percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6 percent and 10 percent have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare. There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this

pilot program will identify and collect Medicare claims overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

- There will be RACs for both Medicare Secondary Payer (MSP) and non-MSP claims and activity.
- Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

The following provides additional details about the RACs pilot program:

- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
- RACs will 1) perform data analysis to identify areas of investigation, and 2) request claims history information from the carriers/intermediaries.
- Non-MSP RACs will identify and recover claims overpayments only. They will not be permitted to establish cost report overpayments.
- RACs will apply national coverage policies and Local Coverage Determinations (LCDs) that have been approved by the MACs.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.
- No new policy will be applied. In addition:
    - Providers will be permitted to appeal any negative determinations to their MAC; and
    - If underpayments are determined, the information will be forwarded to the MACs for processing and payment.

CMS selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the Recovery Audit Contracts:

- California
- Florida
- New York

CMS released a Request for Proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claims overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at http://www.cms.hhs.gov/MMAUpdate on the CMS web site.

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 - PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;

(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION -

(1) SCOPE- The project shall cover at least 2 States that are among the States with-

(A) The highest per capita utilization rates of Medicare services, and

(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-

(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary

under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: SE0565
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose.

As the states with the largest Medicare expenditure amounts, California, Florida, and New York were selected for pilot RACs that began earlier this year and that will last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs).

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (DHHS) to demonstrate the use of RACs under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

On January 11, 2005, CMS announced the recovery audit contractor demonstration project. (See MLN Matters article SE0469 which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0469.pdf on the CMS web site.)

The demonstration, mandated by the MMA, will evaluate the use of recovery audit contractors in identifying Medicare underpayments and overpayments and recouping overpayments.

On March 28, 2005, CMS awarded five RACs and officially announced the beginning of the recovery audit contractor demonstration. Three of the five recovery audit contractors will perform post-payment medical review in the states of California, Florida, and New York. Those firms and the state they are responsible for are as follows:

- Connolly Consulting will perform claim reviews for providers who are serviced by a FI or carrier in New York. Connolly Consulting will also perform reviews for durable medical equipment claims for Medicare beneficiaries who reside in New York.
- PRG Schultz and its subcontractor, Concentra Preferred Systems, will perform claim reviews for providers who are serviced by a FI or carrier in California. PRG Schultz will also perform reviews for durable medical equipment claims for beneficiaries who reside in California.
- HealthData Insights will perform claim reviews for providers who are serviced by a FI or carrier in Florida. HealthData Insights will also perform reviews for durable medical equipment claims for beneficiaries who reside in Florida.

CMS is committed to alerting the provider community regarding the focus of the recovery audit contractor demonstration. The recovery auditors have at least three years of claims they may review.

Three-Tiered Review Process

The recovery audit contractors have a three-tiered process that is explained below:

- The first level involves Part A Diagnosis Related Group (DRG) reviews. These reviews normally involve making a request for medical records. Providers located in Florida began seeing medical record requests in August. Providers located in New York began seeing medical record requests in September. California providers will see medical record requests some time after October.

- The second level involves overpayments determined by the recovery audit contractor's proprietary data mining systems. These are overpayments that clearly do not meet the requirements of Medicare policies. These overpayments do not require a medical record request because it is very clear that an overpayment has occurred. These overpayments may be for a Part A or Part B service.

However, CMS is approving a sample of these overpayments before the demand letters are released. In October 2005, physicians and/or providers in Florida may receive overpayment demand letters resulting from these automated reviews. Beginning in October, physicians and/or providers in California and New York may also see overpayment demand letters resulting from these reviews.

- The last level involves the actual request of medical records for Part B services. All of the recovery companies have indicated that physicians may see medical record requests for Part B services in October or November of 2005. In a future MLN Matters article, CMS will update the provider community when medical record requests could be made.

Note: Questions concerning the recovery audit contractor demonstration may be directed to an email address CMS has established for the demonstration. That email address is cmsrecoveryauditdemo@cms.hhs.gov.

Additional Information

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Functional Contractors Overview

By 2010, the Medicare Administrative Contractor (MAC) will be the central point in the Agency's national fee-for-service program. The establishment and monitoring of the relationships within this program is critical to the integrity of the MAC contract administration. Functional contractors will play an essential role.

- **Beneficiary Contact Center (BCC)**
  The BCC is assuming the duties traditionally held by fiscal intermediaries and carriers. In the BCC environment, beneficiaries have a single Medicare point-of-contact, a 1-800-MEDICARE call center operated by CMS that that will connect them to a seamless network of customer service entities that can answer Medicare and related questions and resolve problems.

- **Enterprise Data Center (EDC)**
  A data center is an entity that houses claims processing software systems for Medicare claims. The EDC is consolidating the large number of data centers currently servicing Medicare Fee-For-Service contractors. There are three contractors on the EDC Indefinite Delivery Indefinite Quantity contract, which was awarded in February 2006.

- **Healthcare Integrated General Ledger and Account System (HIGLAS)**
  HIGLAS is the new general ledger accounting system that will replace the Contractor Administrative Budget and Finance Management system, also know as CAFM, functions. Where possible, the transition to the HIGLAS accounting system is aligned to the MAC implementation schedule to avoid having the MAC use multiple systems in reporting/tracking financial data.

- **Medicare Secondary Payer Recovery Contractor (MSPRC)**
  The MSPRC is responsible for recovering overpayments where Medicare was not the primary payer. The MAC will continue to accept unsolicited refunds and will continue working any MSP debt currently in HIGLAS.

- **National Medicare Banking Contractor (NMBC**)
  The NMBC will provide reimbursement to MACs to cover all costs incurred in the administration of the Medicare program and for the payment of all checks/electronic funds transfer items presented to the bank for covered Medicare services.

- **Program Safeguard Contractors (PSCs)**
  The PSCs perform functions to ensure the integrity of the Medicare Program. Each MAC will interact with one PSC to handle fraud and abuse issues within their jurisdictions.
  (See tab # 20 for additional information on PSCs)

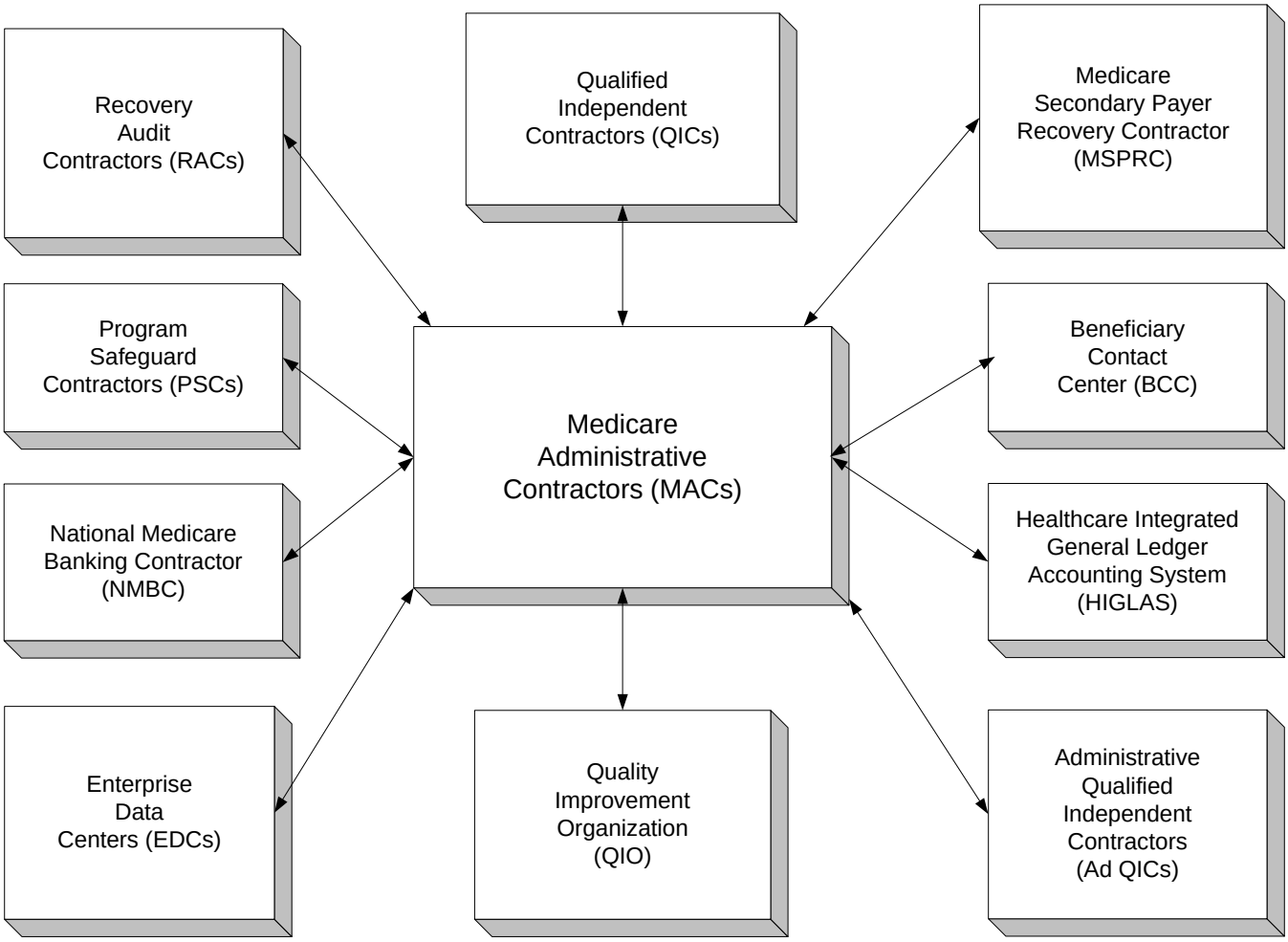
- **Qualified Independent Contractors (QICs)**
  The QICs are responsible for conducting the second level of appeals (reconsiderations of initial determinations and redeterminations of Medicare claims). The MAC is responsible for handling the first level of appeals. The QIC task order establishing three jurisdictions (north, south, and Durable Medical Equipment) to account for MACs was awarded in September 2006.
  (See tab # 21 for additional information on QICs)

- **Quality Improvement Organization (QIO)**
  The QIO is an organization of a group of practicing doctors and other health care experts that are paid by the federal government to review and improve the care given to Medicare patients. QIOs review complaints about the quality of health care services given to Medicare beneficiaries and certain appeals determinations of services in acute care hospitals, skilled nursing facilities, Comprehensive Outpatient Rehabilitation Facilities, and home health agencies. QIOs also review cases from acute care hospitals and long-term care hospitals to make sure the care was medically necessary, provided in the appropriate setting, and coded correctly.

- **Recovery Audit Contractors (RACs)**
  The RACs, are responsible for identifying improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.

- **Shared System Maintainers (SSMs)**
  Medicare requires implementation of a limited number of shared systems by all contractors for their claims process and related functions. This eliminates the need for each to repeat development of the basic system.

Medicare Fee-for-Service Program
Administrative Functional Environment



Medicare Secondary Payer Fact Sheet

June 2007 *for Provider, Physician, and Other Supplier Billing Staff*

Background

Maintaining the viability and integrity of the Medicare Trust Fund becomes critical as the Medicare Program matures and the "baby boomer" generation moves toward retirement. Providers, physicians, and other suppliers can contribute to the appropriate use of Medicare by complying with all Medicare requirements, including those applicable to the Medicare Secondary Payer (MSP) provisions. The purpose of this Fact Sheet is to provide a general overview of the MSP provisions for individuals involved in the admission and billing procedures at provider, physician, and other supplier settings.

What is Medicare Secondary Payer (MSP)?

Since 1980, the Medicare Secondary Payer (MSP) provisions have protected Medicare funds by ensuring that Medicare does not pay for services and items that certain health insurance or coverage has primary responsibilities for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary insurance. It provides the following benefits for both the Medicare program and providers, physicians, and other suppliers:

- National program savings - Medicare saves more than $4.5 billion annually on claims processed by insurers that are primary to Medicare.
- Increased provider, physician, and other supplier revenue - Providers, physicians, and other suppliers that bill a liability insurer *before* billing Medicare may receive more favorable payment rates. Providers, physicians, and other suppliers can also reduce administrative costs when health insurance or coverage is properly coordinated.
- Avoidance of Medicare recovery efforts - Providers, physicians, and other suppliers that file claims correctly the first time may prevent future Medicare recovery efforts on that claim.

To realize these benefits, providers, physicians, and other suppliers must have access to accurate, up-to-date information about all health insurance or coverage that Medicare beneficiaries may have. Current law and regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items.

When Does Medicare Pay First?

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in other instances, provided several conditions are met. Table 1 lists some common situations when Medicare may be the primary or secondary payer for a patient's claims:

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Medicare Secondary Payer Fact Sheet

IF THE PATIENT...	AND THIS CONDITION EXISTS...	THEN THIS PROGRAM PAYS FIRST...	AND THIS PROGRAM PAYS SECOND
Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...	The employer has less than 20 employees...	**Medicare**	Group Health Plan
	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals...	Group Health Plan	**Medicare**
Has an employer retirement plan and is age 65 or older or disabled and age 65 or older...	The patient is entitled to Medicare...	**Medicare**	Retiree coverage
Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment	The employer has less than 100 employees...	**Medicare**	Large Group Health Plan
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	Large Group Health Plan	**Medicare**
Has End Stage Renal Disease and Group Health Plan Coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	Group Health Plan	**Medicare**
	After 30 months...	**Medicare**	Group Health Plan
Has End Stage Renal Disease and COBRA coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	**Medicare**
	After 30 months...	**Medicare**	COBRA
Is covered under Workers' Compensation because of a job-related illness or injury...	The patient is entitled to Medicare...	Workers' Compensation (for health care items or services related to job-related illness or injury). Payment may be made from a Workers' Compensation Medicare Set-aside Arrangement.	**Medicare**
Has been in an accident or other situation where no-fault or liability insurance is involved...	The patient is entitled to Medicare...	No-fault or liability insurance for accident or other situation related health care services	**Medicare**
Is age 65 or older OR is disabled and covered by Medicare and COBRA...	The patient is entitled to Medicare...	**Medicare**	COBRA

Table 1. List of Common Situations When Medicare May Pay First or Second

Are There Any Exceptions to the MSP Requirements?

In most cases, Federal law takes precedence over state laws and private contracts. Even if a state law or insurance policy states that they are a secondary payer to Medicare, the MSP provisions should be followed when billing for services.

What Happens if the Primary Payer Denies a Claim?

In the following situations, Medicare *may* make payment assuming the services are covered and a proper claim has been filed.

- The GHP denies payment for services because the beneficiary is not covered by the health plan;
- The no-fault or liability insurer does not pay, or denies the medical bill; or
- The WC program denies payment, as in situations where WC is not required to pay for a given medical condition.
- The Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is exhausted.

In these situations, providers, physicians, and other suppliers should include documentation from the primary payer stating that the claim has been denied and/or benefits have been exhausted when submitting the claim to Medicare.

When Will Medicare Make a Conditional Payment?

Medicare will make a conditional payment for Medicare covered services in liability, no-fault, and WC situations where another payer is responsible for payment and the claim is not expected to be paid within the "promptly" period. Medicare makes conditional payments to prevent the beneficiary from using his or her own money to pay the claim. However, Medicare has the right to recover any conditional payments.

How Is Beneficiary Health Insurance or Coverage Information Collected and Coordinated?

The Centers for Medicare & Medicaid Services (CMS) established the Coordination of Benefits (COB) Contractor to collect, manage, and maintain information on Medicare's Common Working File (CWF) regarding other health insurance or coverage for Medicare beneficiaries. Providers, physicians, and other suppliers must collect accurate MSP beneficiary information for the COB Contractor to coordinate the information.

To support the goals of the MSP provisions, the COB Contractor manages several data gathering programs. These programs were implemented in three phases, as discussed in the next section.

What Are Some of the Activities Managed by the COB Contractor?

The COB Contractor implemented the first two phases of the contract in April 2000:

- **Initial Enrollment Questionnaire (IEQ)** - The COB Contractor sends out the IEQ approximately three months before an individual is eligible for Medicare. This questionnaire asks the beneficiary if he or she has other health insurance or coverage (including prescription drug coverage) that may be primary to Medicare.

- **Internal Revenue Service/Social Security Administration/CMS (IRS/SSA/CMS) Data Match Project Coordination** - The Omnibus Budget Reconciliation Act of 1989 requires each agency to share information it has regarding employment of Medicare beneficiaries or their spouses. This information helps determine whether a beneficiary may be covered by a Group Health Plan (GHP) that pays primary to Medicare. This information is sent to the COB Contractor, which coordinates the Data Match Project.

- **As part of the Data Match Project,** the Voluntary Data Sharing Agreement (VDSA) program allows for the electronic data exchange of GHP eligibility and Medicare information between CMS, employers, and various insurers (including prescription drug plans). Employers, to meet the mandatory reporting requirements, can sign a VDSA in lieu of completing and submitting the IRS/SSA/CMS Data Match questionnaire. CMS has also developed a new data exchange, similar to the VDSA program, for Supplemental Drug Plans [Non-Qualified State Pharmaceutical Assistance Programs (SPAPs)] to coordinate with Medicare Part D.

In January 2001, an additional phase of the COB contract was implemented:

- **MSP Claims Investigation Process** - The COB Contractor assumed responsibility for all initial MSP development activities previously performed by Intermediaries and Carriers. The COB Contractor provides a one-stop customer service approach for all MSP-related inquiries. However, the COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claim-specific inquiries. Each provider, physician, or other supplier should continue to call the Medicare contractor that processes their claims regarding specific claim-based issues.

What Is the Provider's, Physician's, or Other Supplier's Role in the MSP Provisions?

Providers, physicians, and other suppliers must aid in the collection and coordination of beneficiary health insurance or coverage information by:

- Asking the patient or his/her representative questions concerning the patient's MSP status. A suggested method is to incorporate a MSP questionnaire into all patient health records.

- Billing the primary payer before billing Medicare, as required by the Social Security Act.

How Do Providers, Physicians, and Other Suppliers Gather Accurate Data from the Beneficiary?

Providers, physicians, and other suppliers can save time and money by collecting patient health insurance or coverage information at *each* patient visit. Some suggested questions that providers, physicians, and other suppliers should ask include, but are not limited to:

- Is the patient covered by any GHP through his or her current or former employment? If so, how many employees work for the employer providing coverage?

- Is the patient covered by a GHP through his or her spouse or other family member's current or former employment? If so, how many employees work for the employer providing the GHP?

- Is the patient receiving Workers Compensation (WC) benefits?

- Does the patient have a WCMSA?

- Is the patient covered under no-fault insurance or liability insurance?
- Is the patient being treated for an injury or illness for which another party could be held liable?

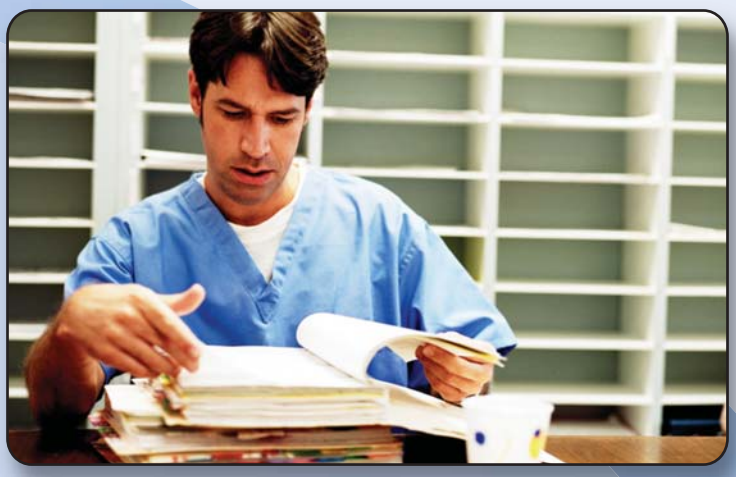
Providers, physicians, and other suppliers may also use a model questionnaire published by CMS to collect patient information. This tool is available online in the MSP Manual in chapter 3, section 20.2.1 at *http://www.cms.hhs.gov/manuals/downloads/msp105c03.pdf* on the CMS website.

If the provider, physician, or other supplier does not furnish Medicare with a record of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the COB Contractor may request that the provider, physician, or other supplier complete a Development Questionnaire.

Why Gather Additional Beneficiary Health Insurance or Coverage Information?

The goal of MSP information-gathering activities is to quickly identify possible MSP situations, thus ensuring correct primary and secondary payments by the responsible parties. This effort may require that providers, physicians, and other suppliers complete Development Questionnaires to collect accurate beneficiary health insurance or coverage information. Many of the questions on the Development Questionnaires are similar to the questions that providers, physicians, and other suppliers might ask a beneficiary during a routine visit. This similarity provides another good reason to routinely ask patients about their health insurance or coverage. If a provider, physician, or other supplier gathers information about a beneficiary's other health insurance or coverage and uses that information to complete the claim properly, a Development Questionnaire may not be necessary. Accurate submittal of claims may accelerate the processing of the provider's, physician's, or other supplier's claim.

The COB Contractor may submit a Secondary Claim Development (SCD) Questionnaire to providers, physicians, and other suppliers.



What Is a Secondary Claim Development (SCD) Questionnaire?

An SCD Questionnaire may be sent to the provider, physician, or other supplier when a claim is submitted with an Explanation of Benefits (EOB) attached from an insurer other than Medicare, and relevant information was not submitted to properly adjudicate the submitted claim. The COB Contractor provides the names and Health Insurance Claim Number (HICN) of each individual for which the provider, physician, or other supplier must complete an SCD Questionnaire. The provider, physician, or other supplier must complete and submit the SCD Questionnaire to the COB Contractor.

What Happens if the Provider, Physician, or Other Supplier Submits a Claim to Medicare Without Providing the Other Insurer's Information?

The claim may be paid if it meets all Medicare requirements, including Medicare coverage and medical necessity guidelines. However, if the beneficiary's Medicare record indicates that another insurer should have paid primary to Medicare, the claim will be either returned unprocessed to the provider or denied or suspended for development. If the Medicare contractor

has enough information, they may forward the information to the COBC and the COBC may send the provider, physician, or other supplier a Secondary Claim Development Questionnaire to complete for additional information if they were the informant. Medicare will review the information on the questionnaire and determine the proper action to take.

What Happens if the Provider, Physician, or Other Supplier Fails to File Correct and Accurate Claims with Medicare?

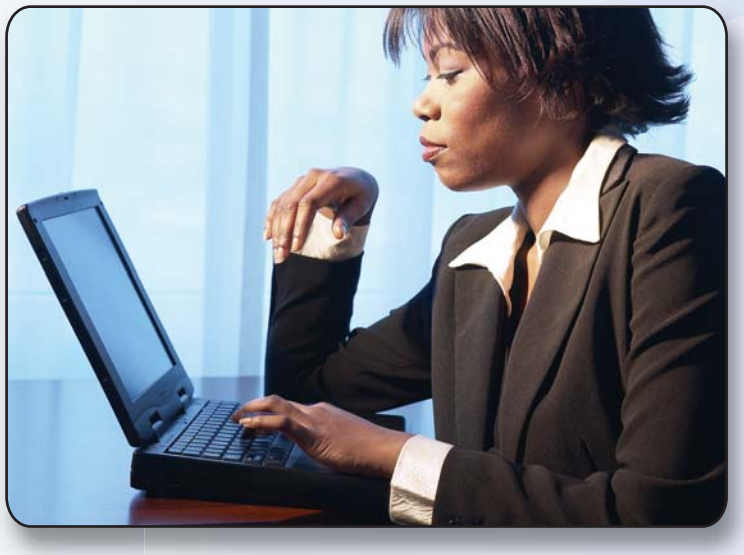
Federal law permits Medicare to recover its conditional payments. Providers, physicians, and other suppliers can be fined up to $2,000 for knowingly, willfully, and repeatedly providing inaccurate information relating to the existence of other health insurance or coverage.

How Does the Provider, Physician, or Other Supplier Contact the COB Contractor?

Providers, physicians, and other suppliers may contact the COB Contractor at 1-800-999-1118 (TTY/TDD: 1-800-318-8782), Monday - Friday, 8 a.m. to 8 p.m. Eastern Time (excluding holidays). Providers, physicians, and other suppliers may contact the COB Contractor to:

- Report potential MSP situations;
- Report incorrect insurance information; or
- Address general MSP questions/concerns.

Specific claim-based issues (including claim processing) should still be addressed to the provider's, physician's, or other supplier's Medicare claims processing contractor[1].



Are There Any Other Contractors That Identify MSP Situations?

In addition to the COB Contract, Medicare has a demonstration project in place to assist with the identification of claims that should have had an alternate primary payer. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) mandated a 3-year project to demonstrate the use of Recovery Audit Contractors (RACs) in identifying underpayments, overpayments, and Medicare Secondary Payer situations for Medicare claims.

The RAC Demonstration Project consists of two different types of audit contractors: Claim RACs and MSP RACs. The Claim RACs are tasked with identifying underpayments and overpayments made on Medicare claims, while the MSP RACs are responsible for identifying claims where Medicare was not the primary payer. The RAC Demonstration is currently operating in three states with the highest rate of Medicare utilization: California, Florida, and New York.

For more information about the RAC demonstration, including MLN Matters articles on the topic, and a Frequently Asked Questions list, please visit *http://www.cms.hhs.gov/RAC/* on the CMS website.

[1]**Medicare Contracting Reform (MCR) Update** - Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

Where Can I Find More Information on the Provider's, Physician's, or Other Supplier's Role in MSP and COB?

CMS offers several online references for information about MSP, COB, and the Medicare Program:

- **The Medicare Learning Network Home Page**

  The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

- **The Medicare Coordination of Benefits Home Page**

  http://www.cms.hhs.gov/COBGeneralInformation/

  The Medicare Coordination of Benefits Home Page features materials related to the MSP provisions.

- **The Contacting the COB Contractor Web Page**

  http://www.cms.hhs.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp

  The Contacting the COB Contractor Web Page contains the contact information and specific addresses for submitting COB Contractor-requested materials.

Medicare Secondary Payer (MSP) Manual

Chapter 8 - Affiliated Contractor Interaction with Medicare Secondary Payer (MSP) Recovery Audit Contractors (RACs)

Table of Contents

(Rev. 24, 02-18-05)

80 - Administrative Costs Incurred by Affiliated Contractors

Exhibit 1

10 - Medicare Secondary Payer (MSP) Recovery Audit Contractors (RACs)

Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Section 306 of the Medicare Modernization Act (MMA) is entitled "Demonstration Project for Use of Recovery Audit Contractors". This provision requires the Secretary to conduct a demonstration project for not longer than three (3) years to identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services. A Report to Congress is required six months after completion of the project. The report will contain analysis specific to the impact of the demonstration on Medicare savings and recommendations on extending or expanding the project.

CMS decided to establish MSP RACs in the following states:

- California
- Florida
- New York

These instructions apply to the following contractors: UGS-CA #454, NHIC-N. CA #31140, NHIC-S. CA #31146, First Coast Service Options (A) #090, First Coast Service Options (B) #590, Empire (A) #308, Empire (B) #803, GHI-NY #14330, Healthnow-NY #801, and to the DMERCs for beneficiaries residing in the states of California-Cigna #5655, Florida-Palmetto #885 and New York-Healthnow #811. These contractors are hereby referred to as "affiliated contractors" throughout these instructions. The affiliated contractors shall interact with their affiliated RAC.

NOTE: The affiliated contractor is excluded from recovery on a RAC identified GHP occurrence **ONLY** if the RAC is its affiliated RAC.

20 - Affiliated Contractor GHP Recovery Process Expansions

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

(Subset of IOM Pub.100-5 MSP Chapter 7 Section 10.2) Affiliated contractors shall recognize these instructions as additional processes necessary to accommodate their interactions with their affiliated RAC.

20.1 - GHP History Search

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Just as today, the affiliated contractors shall search their claims history for the time period specified in the Budget Performance Requirements (BPR) to determine if payments have been made related to a newly accreted MSP record that equal or exceed the recovery tolerance for Group Health Plan (GHP) cases.

20.2 - Identification of RAC Created GHP Records

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

In addition to their current CWF validation process prior to the issuance of any demand, affiliated contractors shall identify all RAC identified beneficiary records, which have been created by the RAC assigned to the affiliated contractor's state.

- Check the CWF MSP auxiliary file to validate the record and determine originating contractor.

    1. If the record is present and contains all employer and insurer information, each affiliated contractor shall identify the contractor number of the originating contractor (the contractor who was responsible for the creation of the record).

    2. If the originating contractor number is a RAC contractor number (11125 with a CWF source code of 25, 11126 with a CWF source code of 26 or 11127 with a CWF source code of 27), the affiliated contractor will confirm the relationship of the originating RAC contractor with their state. For example: RAC 11125 will be assigned to California, 11126 will be assigned to Florida and 11127 will be assigned to New York. The California affiliated contractor has a relationship with RAC 11125, no other RAC.

20.3 - Exclusion of RAC Identified Records from AC Recoveries

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall not initiate recoveries on MSP beneficiary GHP records that were identified and created as a result of their related RACs involvement. (In the event a contractors shared system creates the accounts receivable (A/R) upon the request for history, the contractor shall make appropriate adjustments to the A/R to ensure no demand is made on claims associated to the MSP GHP record created by the RAC. Upon HIGLAS implementation the debt shall be adjusted within HIGLAS. The ReMAS interface of GHP debts to HIGLAS will be done systematically/automatically so that there will be no chance to catch this situation before the debt is created.

20.4 - Subsequent Recovery Process

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

From this step, affiliated contractors shall follow all existing instructions specific to MSP recovery. (IOM Pub.100-05, Chapter 7 and IOM Pub.100-06, Chapter 5.)

30 - Transfer of RAC Identified GHP Duplicate Primary Payments (DPP) to the Affiliated Contractor

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

(Subset of IOM Pub.100-05 MSP Chapter 7 Section 10.3.B.)

30.1 - GHP DPP Referrals and AC Recovery Process

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

RACs shall refer all notices of duplicate primary payment to their affiliated contractor's. The RAC shall send claims information and detail identified as having had a duplicate primary payment (i.e., the debtor responds to RAC that it "paid the provider") to their appropriate affiliated contractor(s). At a later date, each affiliated contractor will be asked for a point of contact for all referrals/transfers from its affiliated RAC contractor(s).

- The affiliated contractors shall follow standard operating procedures specific to provider, physician or other supplier recovery of duplicate primary payments.

- If the DPP overpayment had previously been recovered due to credit balance reporting, provider claim adjustment, etc., the affiliated contractor shall relay this information via the DPP Report to the Project Officer and shall not initiate a demand for repayment.

30.2 - AC Reconciliation of Appeal Request

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

If the event the affiliated contractor receives an appeal request (i.e., a Re-determination request) specific to the referred DPP situation, the affiliated contractor shall make an appeal determination and report the status of any DPP appeal on the monthly report to the Project Officer. (See Exhibit 1 for the required format for all DPP activity.)

The affiliated contractor shall create a DPP hardcopy case folder containing the initial notification/transfer of the DPP by the RAC, a copy of the demand letter, all subsequent correspondence specific to the debt and the date and amount actually recovered either by the affiliated contractor or through cross-servicing efforts.

40 - Avoidance of Recovery Overlap

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

(Subset of Financial Management Manual, IOM Pub.100-6 Chapter 5 and Medicare Secondary Payer, IOM Pub.100-5 Chapter 7)

40.1 - AC Response to Refund Request from RAC

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

In some instances, the MSP occurrence accepted as a valid RAC identified GHP occurrence may later be determined, by the Coordination of Benefits Contractor (COBC), to be invalid. If claims have been recovered in error, a refund of the recovery amount may need to be issued (if the funds are not applied to other outstanding debts of the debtor). The RAC does not have the authority to make refunds (and does not have the authority to determine if the recovered amounts can be applied to other outstanding debts of the debtor).

- The RAC shall notify and supply to its affiliated contractor all requests to refund along with all documentation to support the refund. The affiliated contractor shall follow their standard operating procedure regarding refunds (See IOM Pub.100-6 Financial Management Manual Chapter 5 for instructions).

40.2 - AC Response /Role to Subsequent VDSA and DM Records

(*Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)*

In certain situations where the RAC has identified an MSP occurrence that occurrence is subsequently identified through a Voluntary Data Sharing Agreement (VDSA) submission or Data Match response, the RAC shall be notified by COBC to cease recovery efforts. The COBC will delete the RAC record and create a new record with the appropriate originating contractor number.

- The affiliated contractor shall capture this new record in their next scheduled GHP history search and shall take appropriate recovery actions.

When the RAC receives payment specific to this situation, the RAC shall send a copy of the case file to the affiliated contractor.

- The affiliated contractor shall ensure duplicate recovery does not take place on claims for which payment had already been received.

- The affiliated contractor shall issue any applicable refund when timing issues result in a duplicate recovery.

If the RAC was unsuccessful in its recovery attempts and refers the debt to Treasury prior to the VDSA submission or Data match response, the RAC shall obtain all recovery information from CMS's Central Office Division of Financial Reporting and Debt

Referral and recall the remainder of the debt from Treasury. If funds had been recovered through Treasury efforts, the RAC shall copy the entire case, including claim specific information on Treasury recoveries, and send it to its affiliated contractor.

- The affiliated contractor shall use this information to ensure duplicate claim recoveries are not made specific to the newly accreted VDSA or Data match record.

40.3 - AC Response to 42 CFR 411.25 Notice and RAC Involvement

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Section 1862(b)(2)(B)(ii) [42 U.S.C. 1395y(b)(2)(B)(ii)] states, in part, "…an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title … if it is demonstrated that such primary plan has or had a responsibility to make payment..." This situation is often referred to as a "42 CFR 411.25 notice situation."

The responsible entity identifying a 42 CFR 411.25 situation should notify Medicare and repay Medicare the lesser of: (1) the amount Medicare actually paid; and the (2) amount of the insurer's full primary payment obligation.

- Upon receipt of the 42 CFR 411.25 notice, the affiliated contractor shall follow existing CMS instructions regarding the recovery of funds associated with the notice (if the notice is not accompanied by an appropriate repayment) **or** the posting of funds as a result of the notifying entity's compliance with its statutory obligation to repay.

- When the affiliated contractor receives a 42 CFR 411.25 notice, with or without payment, which has a corresponding GHP occurrence initiated by its affiliated RAC, the contractor shall notify its affiliated RAC and the Project Officer to determine the current status and date of any demand or repayment. The affiliated contractor shall ensure no duplication of recovery takes place.

- Where a 42 CFR 411.25 notice is received without accompanying payment --

  - If the RAC issued a demand prior to the receipt date of the notice, and the notice contains no information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan, the RAC continues its collection efforts. The affiliated contractor shall send all information specific to the notice to its affiliated RAC. The affiliated contractor takes no further action.

  - If the RAC issued a demand prior to the receipt date of the notice, and the notice contains information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan, the affiliated contractor shall

inform the RAC of any claims associated with the notice as the RAC shall cease recovery efforts on those claims. The affiliated contractor shall follow standard operating procedures specific to DPP recovery on the claims.

- If the RAC issued a demand on or after the receipt date of the notice or if the RAC has not issued a demand, the RAC shall cease collection efforts. The affiliated contractor shall take appropriate recovery actions.

- Where a 42 CFR 411.25 notice is received with payment –

  - If the RAC issued a demand prior to the receipt date of the notice and check or claim adjustment, and the notice contains no information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan, the RAC continues its pursuit on any recovery claims associated with the MSP occurrence that have not been repaid. The affiliated contractor shall inform the RAC of claims associated with the payment received.

  - If the RAC issued a demand prior to the receipt date of the notice and check or claim adjustment, and the notice contains information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan for claims not included in the repayment amount, the RAC shall cease recovery efforts for such claims. The affiliated contractor shall follow standard operating procedures specific to DPP recovery on the claims.

  - If the RAC issued a demand on or after the receipt date of the notice and check or claim adjustment or if the RAC has not issued a demand, the RAC shall cease collection efforts. The affiliated contractor shall take appropriate recovery actions.

- Where the affiliated contractor determines there is no existing CWF record, it shall await COBC development and record creation prior to initiating further recoveries. Where the affiliated contractor has information that the COBC received the 42 CFR 411.25 notice at the same time as the affiliated contractor, it shall send no ECRS inquiry. In the event the contractor cannot determine whether COBC has simultaneously been notified of the notice, the affiliated contractor shall send an ECRS MSP inquiry transaction.

40.4 - AC Response to Voluntary/Unsolicited Refunds and RAC

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Upon receipt of a voluntary/unsolicited refund by the affiliated contractor or referral of a voluntary/unsolicited refund from the RAC, the affiliated contractor shall follow existing

procedures along with the processes defined below. See also Pub. 100-6 Transmittal 50 issued July 30, 2004 (CR 3274).

- If the voluntary/unsolicited refund is specific to a GHP issue, the affiliated contractor shall confirm if a GHP record exists on CWF **and** if the record is attributed to the contractor's affiliated RAC. If "yes" to both of these conditions --

  - If the RAC issued a demand prior to the receipt date of the unsolicited/voluntary refund, and the notice contains no information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan, the RAC continues its pursuit on any recovery claims associated with the MSP occurrence that have not been repaid. The affiliated contractor shall inform the RAC of claims associated with the payment received.

  - If the RAC issued a demand prior to the receipt date of the unsolicited/voluntary refund, and it contains information that the provider, physician, or other supplier has been paid by the GHP insurer/TPA/plan for claims not included in the repayment amount, the RAC shall cease recovery efforts for such claims. The affiliated contractor shall follow standard operating procedures specific to the DPP recovery effort on the claims.

  - If the RAC issued a demand on or after the receipt date of the unsolicited/voluntary refund or if the RAC has not issued a demand, the RAC shall cease collection efforts associated with the MSP occurrence. The affiliated contractor shall follow instructions in Pub. 100-6 Transmittal 50 (CR 3274).

50 - Affiliated Contractor Actions for Exhaustible Benefits and MSP Savings

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

(Subset of IOM Pub.100-5 MSP Chapter 7 Section 60)

The RAC shall notify each appropriate affiliated contractor of any claims it has recovered for which exhaustible benefits would need to be re-established. The RAC shall supply to each appropriate affiliated contractor a list of that affiliated contractor's affected claims and the associated recovery amounts.

- The affiliated contractor shall re-establish exhaustible benefits specific to the recovery and claims referred by the RAC.

CMS may also direct affiliated contractors to manually report additional RAC MSP savings. In the event this occurs, the instruction will be given in a subsequent CR.

60 - Misrouted inquiries (phone/paper/fax) related to RAC Recovery Efforts

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

The affiliated contractor receiving inquiries either by phone, fax or hardcopy paper inquiries specific to a beneficiary where CWF currently shows the MSP occurrence was identified by the RAC, shall document the phone conversation and refer the documentation to the RAC. The method of referral may be fax. The affiliated contractor shall supply the inquirer the appropriate RAC telephone number. Listed are each RACs Point of Contact, addresses and phone numbers:

California: RAC (TBD)

Florida: RAC (TBD)

New York: RAC (TBD)

70 - Tracking and Reporting RAC Interactions

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

70.1 - RAC Referred DPP Report

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall report DPP referrals from their affiliated RAC. The report for the preceding month is due to the Project Officer in an EXCEL format by the 10th calendar day of each month. The report shall include the following categories: Date of Referral, Date of Demand, Amount of Demand, Amount Collected, Status of Overpayment (use Exhibit 1). The affiliated contractor shall report all RAC referred DPP affiliated contractor efforts within Activity code 42006 under workload 2.

70.2 - RAC Notice of Refund Report

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall report debt specific information regarding all RAC Refund Requests. The report for the preceding month is due to the Project Officer in an EXCEL format by the 10th calendar day of each month. The affiliated contractor shall include a column with the reason for each refund. Reason descriptors shall include: 1) erroneous beneficiary record creation, 2) appeal decision favorable to provider/supplier (for DPP), etc. (See prior Sections to determine refund applicability.) The affiliated contractor shall report all RAC initiated refund requests and affiliated contractor efforts within Activity Code 42006 under workload 3.

70.3 - Report on Manual Exclusion Efforts Associated with RAC Identified MSP Occurrences

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall report on a beneficiary-specific basis the MSP occurrences for which they have had to take manual interventions to exclude associated debts from their systematically identified potential demand universe for either Data Match or retro-recoveries. The report for the preceding month is due to the Project Officer in an EXCEL format by the 10th calendar day of each month. Affiliated contractors shall quantify, on the report, the time and cost to ensure no duplication of recovery occurred. The affiliated contractors shall show this figure in your monthly report for Activity code 42006 under workload 1.

70.4 - Report of Requests to Re-Establish Exhaustible Benefits

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall report a listing of beneficiaries for which exhaustible benefits were re-established due to RAC notification as specified in Section 50 above. The report for the preceding month is due to the Project Officer in an EXCEL format by the 10th calendar day of each month. CMS may also direct affiliated contractors to manually report additional RAC MSP savings at a later date.

80 - Administrative Costs Incurred by Medicare Contractors

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

Affiliated contractors shall track all direct and indirect costs associated with **all** RAC interactions, as defined above, within Activity Code 42006. This code is currently not in use and will provide one single venue affiliated contractors to report RAC support and RAC related costs. The required reports in Section 70 address specific workload items. Affiliated contractors shall track the number of excluded beneficiaries as a result of the RAC identification in workload 1, the number of DPP demands in workload 2 and the number of refund requests from the RAC in workload 3. Regardless of not having additional workload categories, the affiliated contractors shall track the cost and time of all RAC interactions as part of Tasks under Activity Code 42006.

Exhibit 1

(Rev. 24, Issued: 02-18-05, Effective: 04-01-05, Implementation: 04-04-05)

DPP REFERRALS FROM RAC							
Contr. #	_____				Claim Status		
RAC #	**Dte of Referral**	**Dte of Dmd by AC**	**Amt of Dmd**	**Amt Collected**	**No Dmd**	**Approved Appeal**	**Denied Appeal**

MEDICAL REVIEW DOCUMENTATION GUIDELINES

The Centers for Medicare & Medicaid Services (CMS) requires us to review a sample of claims submitted to verify services billed are covered and are reasonable and necessary. We will notify you if a claim has been selected for medical review. You will receive a letter requesting documentation, and you may access the request for documentation via the remote system.

Following is an alphabetical listing of the services for which we most often request documentation. For each of the services listed, we provide some recommendations for the type of information and/or medical records to submit when we request it. In the event that all documentation is not submitted, a coverage decision will be made based upon the documentation submitted.

If you have questions regarding what type of information to send us, please refer to these guidelines. For example:

- If our message states: PT-Send all Documentation to Support the Services Billed
  - Refer to the Therapy section of the attached guidelines for recommendations on the types of information to submit for our review.

In order to expedite the documentation of medical records received, we recommend that you send the medical records to the following address. If you send them to any other address or via certified mail, we cannot guarantee that they will arrive in our department timely.

WPS Medicare
Medicare Area
P.O. Box 1602
Omaha, NE 68101

Note: Documentation should be submitted to our office no later than 30 days from the date of the request. If a response to our documentation request is not received within 45 days of the date of the request, the claim will be denied. Please be sure to attach either the hardcopy request letter or a remote cover sheet to the top of each set of medical records to expedite handling.

Ambulance (Air or Ground)

- Physician written order for transport (if non-emergency physician ordered)
- Trip record to include:
  - Detailed statement of the condition necessitating the ambulance
  - Point of origin (identify place and complete address)
  - Detailed documentation of condition during transfer
  - Point of destination (name of facility, complete address)
  - Number of loaded miles/cost per mile/mileage charge
  - Minimal or base charge and charge for special items or services with an explanation
  - Statement if patient was admitted as an inpatient
  - Certification and rationale of necessity for non-emergent transfers
  - Certification of bed confinement if applicable

Any further documentation that supports medical necessity of air and/or ground ambulance transport (e.g., emergency room report).

Blood Glucose

- Results of each blood glucose/Accucheck billed
- Physician notification of each blood glucose result
- Documentation that the physician utilized these results to modify the plan of care
- History and physical
- Physician orders and progress notes
- Nurse's notes
- Detailed itemization of charges

Cardiac Rehabilitation

- Physician order(s)
- Diagnosis from physician with date of onset and documentation to support this diagnosis
- Physician progress notes
- Start of care date
- Most recent history and physical
- Initial evaluation for cardiac rehabilitation services
- Electrocardiogram (EKG) strips for each session
- Number of sessions to date
- Documentation reflecting that service is Phase II
- Individual session notes for each day of service provided
- Documentation supporting diagnosis billed

Cardiac Stress Tests

- History and Physical
- Physician order(s)
- Documentation of physician involvement
- Documentation to support all services/treatments were provided as billed
- Reason (diagnosis or signs and symptoms) for test
- Documentation of medication administration, including any contrast material given
- A detailed itemization for all services billed
- Test results
- Copy of radiological report if available
- Copy of physician's interpretation of cardiac stress test

Cataract Surgery

- Preoperative history and physical
- Operative report of surgery
- Statement of degree of functional impairment
- Documentation listing symptomatology
- Documentation indicating preoperative correctable acuity test
  - Standardized measure of the visual functional status, the results of which suggest that the visual functional status can be improved by undergoing cataract extraction with intraocular lens implant

- Examples of such tools include but are not limited to: Activities of Daily Living Scale, the Visual Acuities Questionnaire, or the VF-14

Chest X-Ray

- Physician order(s)
- Signs and symptoms (rationale for radiology test performed)
- Medical diagnosis
- Copy of radiology test performed
- Emergency room records or clinic records to support medical necessity (if applicable)

Note: Pre-operative chest x-ray should have documentation that supports the patient has a medical condition, which may pose a risk factor with the administration of general anesthesia.

Demand Bills - Skilled Nursing Facility (SNF)

- SNF ABN (Formerly known as: Notice of Non-Coverage): The notice reflects the reason for denial. It is signed and dated by the beneficiary or authorized representative. **If the notice is not signed and dated, please include documentation indicating the date and method of notification that was used. This may include, but is not limited to; telephone notification followed by a certified letter and/or social services notes that document the date and method of notification. [*Medicare Claims Processing Manual*, Pub. 100-4, Chapter 30, Section 70]
- Name and telephone number of a SNF contact person
- Completed MDS documentation relating to dates of service billed
- Completed MDS documentation just prior to the SNF Advance Beneficiary Notice (ABN) or Notice of Non-Coverage (if available)
- Documentation to support the reason that services were denied for Medicare coverage – Please include:
  - Hospital and/or admission history and physical
  - Hospital discharge summary
  - Physician orders
  - Physician progress notes
  - Therapy progress notes
  - Treatment logs to identify therapy minutes provided
  - Nursing notes and admission assessment
  - Medication and IV administration records
  - Treatment administration records
  - Skin/wound documentation
  - All other documentation supporting the determination of non-coverage of services

Please refer to the *Medicare Program Integrity Manual* Pub100-8, Chapter 6, Section 6.1.3
http://www.cms.hhs.gov/manuals/downloads/pim83c06.pdf

Dental Surgery

- Physician order(s)
- Diagnosis (rationale for surgery)
- History and physical
- Operative report

- Nurse's notes
- Medication administration record
- Radiology Report (if applicable)
- All documentation for date(s) of service

Electrocardiogram (EKG)

- Physician order(s)
- History and Physical
- Medical diagnosis
- Signs and symptoms (rationale for EKG diagnosis)
- Copy of EKG report or physician's interpretation
- Documentation of any prior and current assessments
- Documentation to support the medical necessity for the EKG

Emergency Room/Cardiac Arrest

- Itemization of 250 & 270 revenue code charges to include:
  - Number of units billed for each item
  - Dollar amount of each item
  - Identification of each item
  - Revenue code billed under
- Documentation of ER time billed under 450 revenue code
- Physician report/orders
- Progress notes of interventions performed and reflecting utilization of items billed
- Medication sheet/code sheet showing medications billed and administered
- Emergency room record

Hemodialysis and Peritoneal Dialysis (End Stage Renal Disease)

- Extra lab tests (not included in or over amount allowed in composite):
  - Physician order(s)
  - Signs and symptoms
  - Prior lab values indicating the need for additional testing
- Extra treatments (over amount allowed in composite):
  - Documented signs and symptoms of fluid overload (mental status changes, shortness of breath, etc.)
  - Pre and post dialysis weights in kilograms
  - Physician order(s)
- X-rays and EKGs (over amount allowed in composite):
  - Signs and symptoms or rationale for x-ray/EKG
  - Physician order(s)
- Drugs (not included in or over amount allowed in composite):
  - Physician order(s)
  - Itemization of pharmacy charges billed to include:
    - Number of doses of each medication administered
    - Dollar amount of each medication
    - Identification of each medication
    - Revenue code billed under
  - Documentation showing amount/dosage administered

- Laboratory test results supporting medical necessity of the drug
- Signs and symptoms

- Hepatitis B immunizations: send anti-hepatitis B core and anti-hepatitis B surface tests results

Hyperbaric Oxygen (HBO)

- Physician progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received, and the assessment of the level of progress made toward achieving the completion of established therapy goals;
- For treatment of soft tissue radionecrosis- documentation of a history of radiation therapy including date and anatomical site of radiation treatments
- Documentation supporting date of skin graft and compromised state of graft site;
- An initial assessment which includes:
  - History and physical
  - Prior medical, surgical &/or previous HBO
  - Prior antibiotic therapy and surgical interventions
  - Any adjunctive treatment currently being rendered;
- Procedure (logs) including ascent time, descent time, and pressurization level
- Lab reports (culture or gram stains) confirm the diagnosis of necrotizing fasciitis
- Any physician to physician communications
- X-Ray findings and/or bone cultures confirming the diagnosis of osteomyelitis
- Previously unsuccessful antibiotic treatment (if applicable)
- Lab and/or x-ray reports to support the presence of gas gangrene
- HBO treatment record showing wound progress
- Documentation of direct physician supervision

Inpatient Psychiatric Facility Services (IPF)

- Certification/Recertification
- Initial psychiatric evaluation to include:
  - Chief complaint;
  - Description of acute illness or exacerbation of chronic illness requiring admission;
  - Current medial history, including medications and evidence of failure at or inability to benefit from a less intensive, outpatient program;
  - Past psychiatric and medical history;
  - History of substance abuse;
  - Family, vocational and social history;
  - Mental status examination, including general appearance and behavior, orientation, affect, motor activity, thought content, long and short term memory, estimate of intelligence, capacity for self harm and harm to others, insight, judgement, capacity for activities or daily living (ADL's)
- Physician order(s)
- Plan of treatment
- Progress notes
- Physician progress notes
- Discharge plan

Inpatient Rehab Facility Prospective Payment System (IRF PPS)

- Pre-Admission Assessment
- Acute Care Documentation
  - Acute care discharge summaries
  - Physician discharge summary as well as discharge summaries for any and all disciplines
- IRF-Patient Assessment Instrument (PAI)
- Physician documentation to include:
  - Admission history and physical including pertinent information from prior acute stay
  - Physician admit and discharge summaries
  - Physician orders
  - Physician progress notes
- Therapy documentation to include:
  - Initial therapy assessment
  - Therapy reassessments
  - Documentation of actual therapy minutes provided
  - Therapy summaries
  - Any therapy grids
  - Copies of therapy notes and/or discharge summaries from any previous outpatient therapy or any therapy in another less intensive setting
- Team conference notes and/or careplans
  - Team conference notes must contain dated participants signatures and professional designations
- Nursing documentation to include:
  - Any nurse's notes and narratives
  - Any nursing treatment sheets
- Discharge summaries for any and all disciplines

Lab

- Physician order(s)
- Medical diagnosis
- Signs and symptoms (rationale for lab performed)
- Lab results for date of service billed
- Itemization of each lab item billed to include:
  - How many labs drawn
  - Dollar amount of each lab
  - Healthcare Common Procedure Coding System (HCPCS) code for each lab
  - Revenue code billed under

Medical /Surgical Supplies

- Physician order(s) and Progress Notes
- Detailed itemization which specifically identifies all supplies billed under 27X (Medical Surgical Supplies) and/or 62X (Medical Surgical Supplies-Extension of 27X) revenue code (s):
  - Itemization of each supply billed to include:
    - Identification of each item
    - Number of supplies utilized

- Dollar amount of each item
- Revenue code billed under

- Documentation that supports that each procedure(s) and/or service(s) was provided as billed which may include Medication and/or Treatment Administration Records
- Diagnosis with date of onset
- History and physical
- Progress notes detailing service provided for each date of service billed
- Operative/Procedure/Progress Notes detailing debridement services and/or Wound Care relevant to the dates of service billed
- Wound Care records including measurements, if applicable

Non-End Stage Renal Disease (ESRD) EPO

- Physician order(s)
- Current history and physical indicating diagnosis for EPO usage
- Progress notes describing and supporting the indications for initiation and subsequent use of EPO
- Laboratory results (hemoglobin or hematocrit test results done for at least three months prior to the billing period, as well as any other available results)
- Medication administration records

Observation

- Nurse's notes including clock time admitted to observation
- Physician order(s) including admission to observation and clock time of discharge orders
- Physician progress notes
- History and physical
- Diagnosis
- Signs and symptoms that warrant observation services
- Medication administration records
- Diagnostic tests and results
- Supporting documentation of all services billed

Observation Service > 48 Hours

- Nurse's notes including clock time of admission to observation bed
- Physician order(s) including admission to observation and clock time of discharge
- Physician progress notes
- History and physical
- Diagnosis
- Signs and symptoms for observation status
- Medication administration records
- Diagnostic tests and results
- Rationale for observation over 48 hours
- Supporting documentation of all services billed

Open Biopsy

- Physician order(s)
- History and physical

- Diagnosis
- Operative Report
- Procedure code for biopsy
- Pathology report

Pharmacy

- Physician order(s)
- Diagnosis
- Signs and symptoms
- Physician progress notes
- Medication log reflecting administration
- Itemization of each pharmacy item billed to include:
  - Number of doses of each medication administered
  - Dollar amount of each medication
  - Identification of medication
  - Revenue code billed under

Psychiatric Services

- Physician order(s)
- Physician certification/re-certification
- Current individualized, multidisciplinary treatment plan to include weekly or monthly treatment summaries that update/revise the plan
- Psychiatric history/assessment by a physician
- All progress notes
- Diagnosis with date of onset
- Medical history and physical
- Psychosocial evaluation/assessments and all other assessments or consultations
- All daily individual and group notes for dates of service
- All electroconvulsive therapy (ECT) records (if service provided)

Note: Hospital Partial Hospitalization Program claims must be submitted with a condition code 41 to reflect PHP. If condition code 41 is not present, the claim is considered outpatient services.

Pulmonary Services

- Physician order(s)
  - Pulmonary Rehab orders need to specify which therapies are ordered, such as PT, OT, and RT
- Diagnosis with date of onset
- Start of care date
- Signs and Symptoms
- Physicians History and physical
- Prior level of function
- Current level of function
- Psychosocial status
- Progress notes detailing service provided for each date of service billed

- Short and long term goals for all therapy regimens
- Treatment plans for all therapy regimens
- Pulmonary function tests results (PFT's)
- Number of sessions to date
- All treatment session notes, which include date, time, procedure or modality and signature with clinician's credentials.

Questionable Covered Procedure (Reproductive Services, Blepharoplasty, Breast Reconstruction, Bariatric Surgery, Transplant Services, etc.)

- Physician order(s)
- Diagnosis (rationale for surgery)
- History and physical
- Operative report
- Nurse's notes
- Medication administration record
- All documentation for date(s) of service
- Visual Fields to support any Blepharoplasty performed
- Actual photograph(s) (if applicable)
- Amount of tissue removed from each breast for breast reduction surgery
- Body Mass index $\geq$ 35 to support any bariatric surgery

Radiation Therapy

- A detailed itemization and supporting documentation for all services billed
- Documentation of history of illness being treated
- Documentation of physician involvement
- Physician order(s) for treatment including current dosage
- Documentation to support all services billed were provided
  - Dosimetry reports
  - Physicist reports
  - Simulation reports
  - Oncology reports
- Documentation of each treatment billed
- Copy of radiological report or physician's interpretation
- Documentation of any contrast material provided

Radiology Services (X-ray, CT Scan, MRI and Ultrasound)

- Physician order(s)
- Signs and Symptoms (rationale for radiology test performed)
- Medical diagnosis
- Copy of radiology test performed with physician interpretation of the results
- Detailed itemization to support revenue code 25X, 27X and/or 62X for the date(s) of service billed in cases which contrast medication material is utilized and/or supplies are used along with radiological examinations
- Documentation of any contrast material provided

Recovery Room

- History and Physical
- Physician pre-operative notes including diagnosis and orders
- Operative records
- Anesthesia records
- Post operative care records (nursing records and physician notes)
- Patient's time in and out of recovery room
- Disposition of patient (discharged, sent to observation, or inpatient care)

Note: Ambulatory Surgical Recovery Room services will not be covered for excluded services such as dental and cosmetic surgery. If these services are needed for complications of dental or cosmetic procedures, then they may be covered.

Respiratory Services

- Physician order(s)
- Diagnosis with date of onset
- History and physical
- Signs and symptoms
- Progress notes detailing service provided for each date of service billed

Rural Health Clinic

- Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient and a brief summary of the episode, disposition, and instructions to the patient
- Reports of physical examinations, diagnostic and laboratory test results, and consultative findings
- All physician's or midlevel providers (MLP) (PA, NP, CNM) orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress
- Signatures of the physician or other health care professional such as the MLP's
- Documentation requiring the patient met the definition of the evaluation and management (E & M) code used

Skilled Nursing Facility Prospective Payment System (PPS)

- Documentation to support the dates of service billed
- Hospital Documentation to include:
  - Hospital discharge summaries
  - Transfer forms
  - Medication administration records
- Documentation to support each of the HIPPS code(s) billed, including notes related to each of the assessment reference date(s) (ARD)
- Minimum Data Set (MDS) Documentation to include:
  - A hardcopy version of each MDS related to the billing period being reviewed
  - Documentation to support **each** of the look back periods requested and documentation to support each of the look back periods which may fall outside of the billing period **(The lookback or observation period is the 7, 14 or 30-day period prior to and ending on the ARD date)**

- Physician Documentation to include:
  - Physician Certifications and Re-certifications for skilled care
    - Including physician signature and date
    - Re-certifications must include the need for continued skilled care
  - Physician orders, including admission orders
  - Physician progress notes
  - Physician History and Physical
- Nursing Documentation to include:
  - Nursing notes and admission assessment
  - Patient care plans
  - Vital sign records
  - Medication & IV administration records
  - Any nursing treatment sheets such as:
    - Skin care/wound care treatment sheets
    - Respiratory treatments and O2 therapy records
- Rehabilitation Documentation to include:
  - Initial therapy evaluations and re-evaluations:
    - Objective and measurable prior level of function and current level of function to support functional decline
  - Rehabilitation therapy notes including progress notes
  - Treatment records, grids or logs
  - Actual therapy minutes provided
- All other documentation supporting the beneficiaries **need for** and **delivery of** the skilled services being provided in the SNF

SPECT Scan (Single Photon Emission Computed Tomography)

- Physician order
- Diagnosis with date of onset
- Signs and/or symptoms to support medical necessity
- History and Physical
- Copy of SPECT scan performed
- Documentation of any contrast material provided
- Documentation to support any first line tests performed prior to SPECT scan
- Documentation to support the medical necessity of using SPECT as a first line study

Therapies (Physical, Occupational and Speech)

- 700/701 Evaluation forms or in-house equivalent to include:
  - Physician order(s)
  - Signed and dated certification by physician
  - Date of evaluation
  - Start of care date
  - Medical diagnosis
  - Treatment diagnosis
  - Onset date
  - Current level of function
  - Prior level of function
  - Treatment plan with long and short term goals

  - Previous therapy administered to include:
    - Date
    - Diagnosis for treatment
    - Modalities administered
- Progress notes detailing service provided for each date of service billed
- Grid reflecting service/HCPCS provided
- Actual minutes provided to support each timed service/HCPCS provided

Note: When submitting records for interim claims for continuous patients, please include the initial evaluation. If a summary of the progress from the previous billing period is available, it is helpful to include that information also.

Wound Care

- Physician order(s) for physical therapy (PT)/wound care services
- Initial evaluation of PT/wound care services
- Wound characteristics such as diameter, depth, color, presence of exudates or necrotic tissue
- Previous wound care services administered to include date and modalities of treatment
- Plan of treatment for PT/wound care services
- Weekly progress notes to include current wound status, measurements (including size and depth), and the treatment provided
- Description of instrument used for selective or sharp debridement (i.e. forceps, scalpel, scissors, tweezers, high-pressure water jet, etc.)
- Treatment grid/log reflecting PT HCPCS billed
- Certification/recertification for PT/wound care services
- Detailed itemization for any 27X (Supplies) or 62X (Supplies) charges
- Actual minutes provided to support each timed service/HCPCS provided

Note: If patient is continued from one billing period to another, include initial evaluation and progress notes/summary of wound progress prior to the service dates billed

LONG TERM ACUTE CARE HOSPITAL (LTCH) DOCUMENTATION REQUEST

- **PLEASE SUBMIT DOCUMENTATION TO SUPPORT ALL LINE ITEMS BILLED FOR THE SERVICES BEING REVIEWED, INCLUDING THOSE SERVICES INCIDENTAL TO OR PART OF YOUR PROTOCOL FOR LONG TERM CARE HOSPITAL.**
- **DOCUMENTATION SHOULD INCLUDE BUT IS NOT LIMITED TO THE FOLLOWING INFORMATION:**
  - UB04
  - Pre-admission screening tools and any appropriate updates
  - Acute care discharge summary
  - Acute care transfer records
  - History and physical
  - Physician orders
  - Physician progress notes
  - Physician consultation documentation
  - Discharge Summary
  - Diagnostic laboratory orders, indications and results
  - Diagnostic/therapeutic radiology orders, indications and results
  - Surgical intervention documentation
  - Documentation to support an interrupted stay
  - Documentation to support any and all procedures ordered and/or performed
  - Nursing documentation to include, but not limited to, initial and daily assessment, treatment records, wound care documentation, medication administration records, etc.
  - Respiratory care documentation to include, but not limited to, initial and daily assessments, ventilator management logs, respiratory plans of care, treatment goals, units of treatment provided, etc.
  - Physical Therapy, Occupational Therapy and Speech-Language Pathology documentation to include, but not limited to, initial and daily assessments, plans of care, treatment goals, units of treatment provided, etc.
  - Nutritional Therapy documentation to include, but not limited to, initial assessments and updates, plans of care and patient goals, etc.
  - Case Management/ Medical Social Work documentation to include, but not limited to, admission screening tools, discharge planning, and coordination of team goals and plans of care

- Team Conference documentation for entire hospital stay to include discharge plans, coordinated plans of care, and team conference attendees and titles
- Documentation to support the need for complex medical care at the level of an LTCH

SHORT TERM ACUTE CARE HOSPITAL(STCH) DOCUMENTATION REQUEST

- UB04
- Pre-admission/admission screening tools and any appropriate updates
- Acute care transfer records
- Physician orders
- History and Physical
- Physician progress notes
- Physician consultation documentation
- Discharge summaries
- Diagnostic laboratory orders, indications and results
- Diagnostic/therapeutic radiology orders, indications and results
- Surgical intervention documentation
- Documentation to support an interrupted stay
- Documentation to support any and all procedures ordered and/or performed
- Nursing documentation to include, but not limited to, initial and daily assessment, treatment records, wound care documentation, medication administration records, etc
- Respiratory care documentation to include, but not limited to, initial and daily assessments, respiratory plans of care, treatment goals, units of treatment provided, etc.
- Physical Therapy, Occupational Therapy and Speech-Language Pathology documentation to include, but not limited to, initial and daily assessments, plans of care, treatment goals, units of treatment provided, etc.
- Nutritional Therapy documentation to include, but not limited to, initial assessments and updates, plans of care, patient goals etc.
- Case Management/ Medical Social Work documentation to include, but not limited to, admission screening tools, discharge planning and coordination of team goals, plans of care, etc.

APPENDIX B

TABLE OF CONTENTS

B. AHA Advisories

RACTrac

The Medicare Recovery Audit Contractor (RAC) program mandates a hospital field response. As an organized community equipped with timely data, we are poised to provide accurate, up-to-date information about the impact of the RAC program on hospitals.

American Hospital Association

AHA has created RACTrac, a Web-based survey that asks hospitals to report quarterly on their RAC experience. Timely data from hospitals will equip AHA and our state association partners with critical information to support our need for improvements to the RAC program.

We need to hear from you!

In the coming months, RACTrac will allow AHA to determine the RAC denial rates, identify trends in reasons for denials and have up-to-date information on the status of Medicare appeals across specific regions, and at the national level. This information will then be used to educate the field, CMS and Congress on changes needed to the program.

RACTrac Key Points

- Web-based survey that will collect RAC experience data from hospitals.
- Sole point of aggregate RAC experience data driving advocacy initiatives.
- Highlights trends in types of services being reviewed and broad reasons for denial.
- Captures appeal activity and administrative burden.
- **FREE** and available to **ALL** hospitals: Claim Management Tool and Survey Tool.
- Quarterly data collection will begin after audits start.

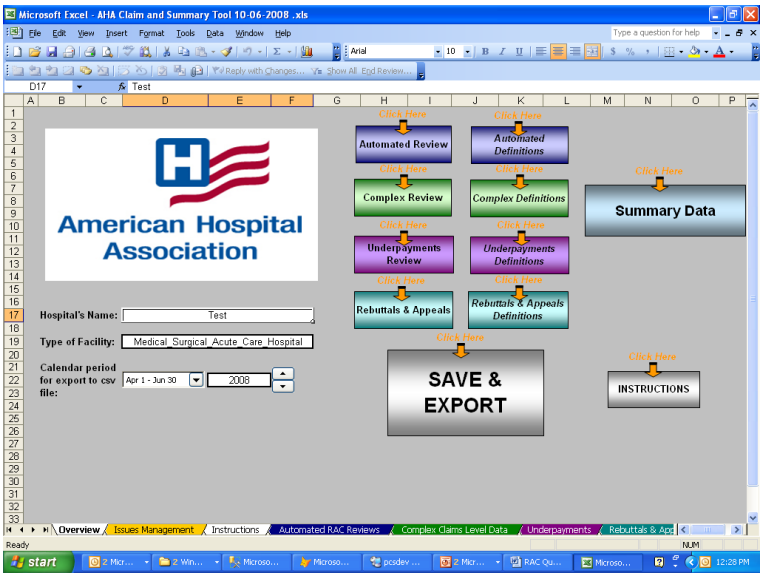
For more information, please contact racinfo@aha.org or visit our Website at www.aha.org/rac.

Coming Soon
www.aharactrac.org

Fill Out the Survey Online or Leverage Technology —RAC Claim Management

AHA is providing a FREE claim management tool to the hospital community. Look for it to be posted to www.aha.org/rac in late November.

AHA is also working with a number of vendors to make their tools RACTrac-compatible. By using the AHA provided tool or a RACTrac-compatible claim management tool … completing the survey is as simple as clicking “Upload Data”.



American Hospital Association

AHA *RACTrac*

November 1, 2008

AHA RACTrac Goals

- **Use RAC experience data collected via survey from hospitals to educate the field about trends in RAC audit activity and to advocate for changes in the RAC program**

- **Make it simple for hospitals to report data to AHA for use in advocacy activities**

American Hospital Association

Pop Quiz:

ARE YOU READY FOR RECOVERY AUDIT CONTRACTORS?

Audits will begin soon!

American Hospital Association

Pop Quiz

- ✓ **Have you appointed a point of contact for all of your RAC correspondence?**
- ✓ **Do you have your RAC team assembled?**
- ✓ **Have you done any self audits to assess your vulnerabilities?**

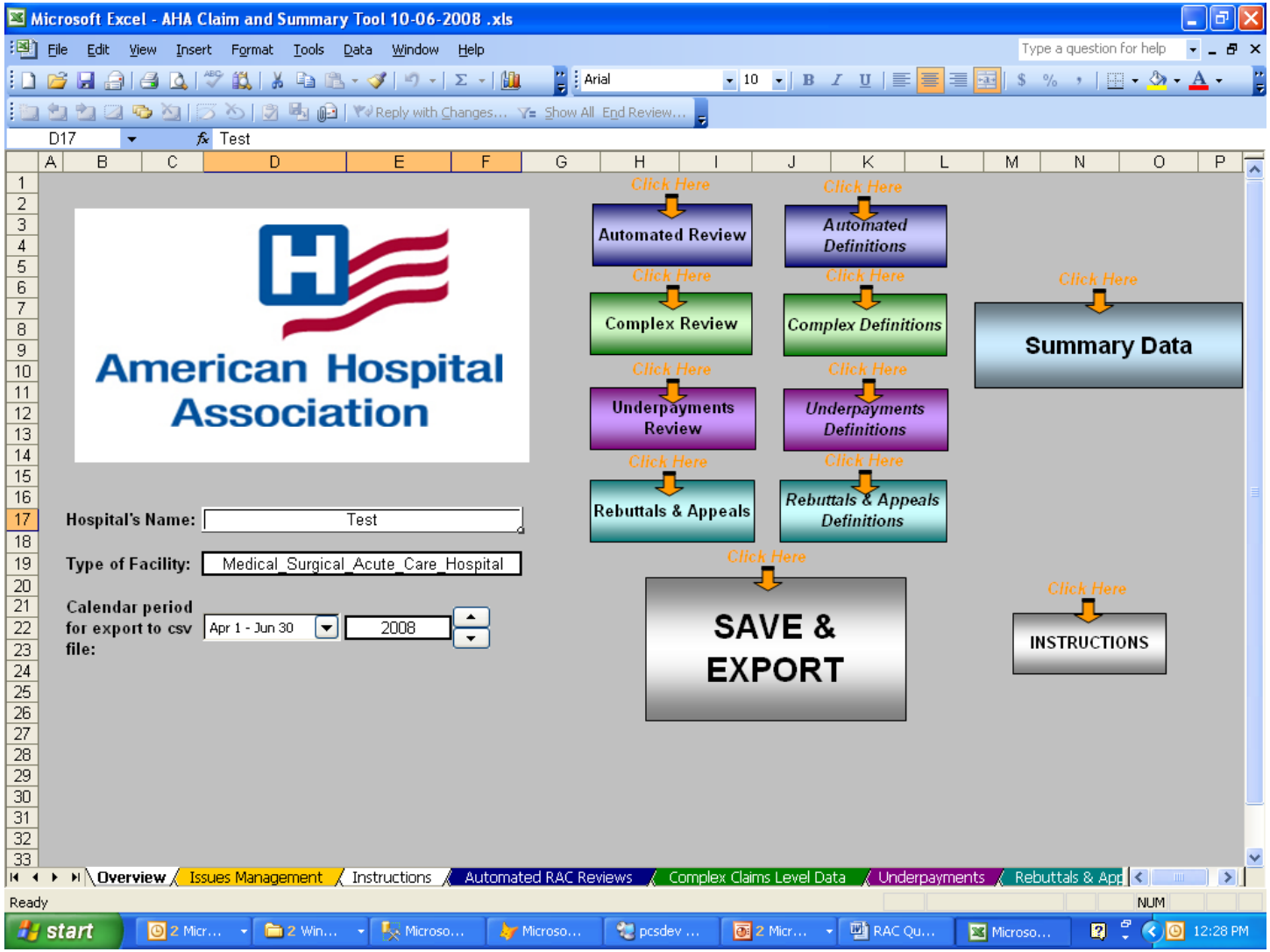
- ✓ **Do you have a mechanism to track all RAC denials, correspondence and timelines?**

AHA RACTrac can help!

- ➢ *1st Identify a mechanism for tracking RAC correspondence, denials and appeals internally*
- ➢ *2nd Prepare to aggregate your RAC experience data to report to the AHA RACTrac survey in 2009*

American Hospital Association

Free Claim Management Tool



Available at www.aha.org/rac in late November

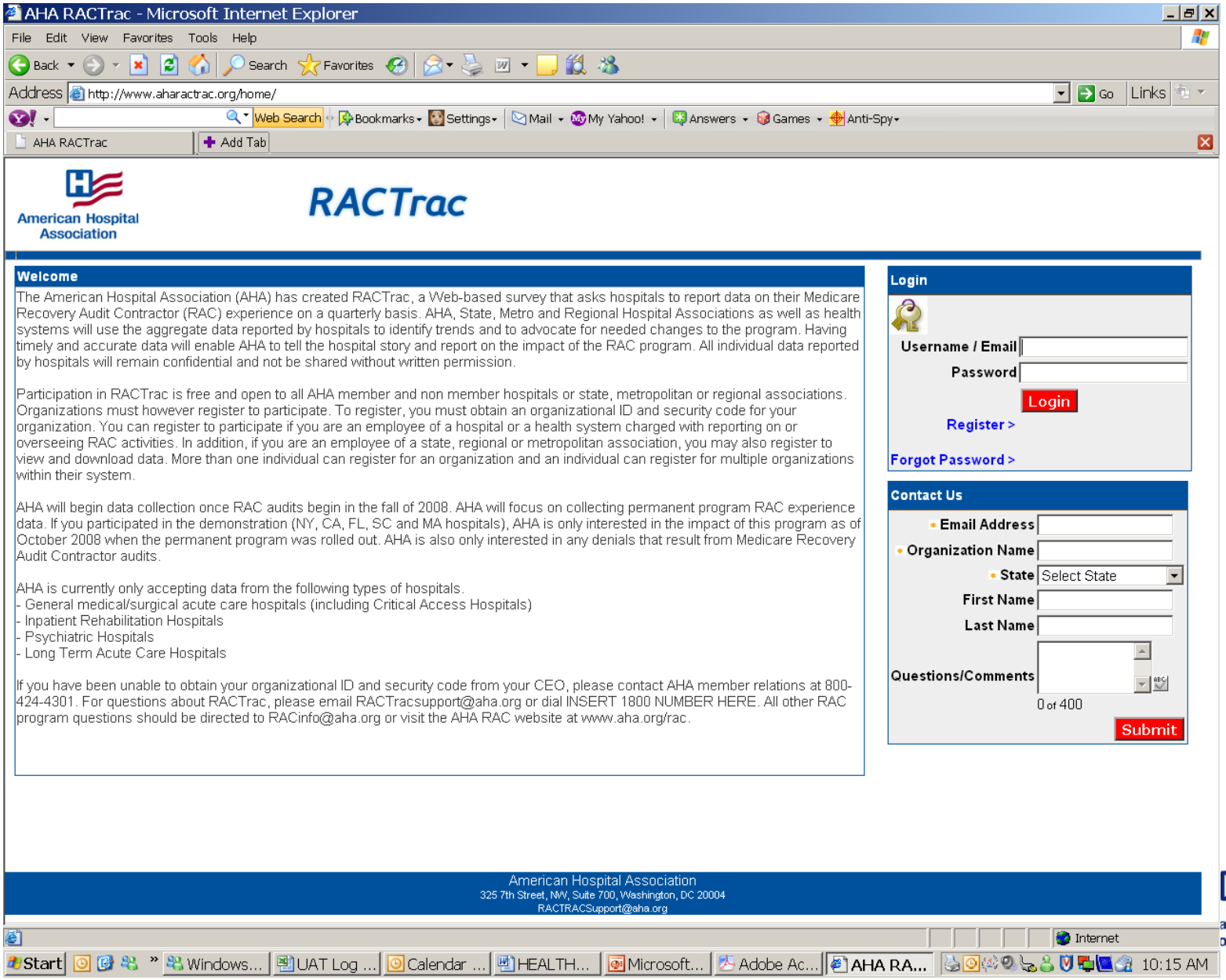
American Hospital Association

Claim Management Tool

- **An Excel Template to get you started in tracking:**
  - Automated denials
  - Medical record requests and denials
  - Underpayments
  - Rebuttals and appeals
- **Microsoft Excel Based Tool**
- **AHA claim management tool will create a summary file for upload into the AHA Web survey**
- **Its FREE and available to all hospitals**
- **Check it out at www.aha.org/rac in late November**

American Hospital Association

www.aharactrac.org



What is AHA RACTrac?

- **Web-based survey that will collect RAC experience data from hospitals**
  - Financial impact (Overpayments and Underpayments)
    - Automatic and complex denials information (numbers and dollars)
  - Trends in types of services being reviewed and broad reasons for denial
  - Appeals information
  - Administrative burden
- **Some questions will be running totals**
  - For example:

  Total number of automatic claim denials to date _____ $_____

  Total number of medical records requested to date _____ $_____
- **Others will be based on the quarter in which we ask the question**
  - For example

  Select the reasons cited by the RACs for complex claim denial for this quarter

  Rank order the denial reasons experienced by number of complex claim denials for this quarter (Greatest number ranked #1 reason etc.)

A complete list of the survey questions will be posted at www.aha.org/rac in late November.

American Hospital Association

What is AHA RACTrac?

- **Unit of analysis is the hospital (and their units)**
  - General Medical/Surgical Hospitals (including CAH's)
    - ✓ This would include units in that hospital (rehab, SNF etc.)
  - Free-standing Long-Term Care Hospitals
  - Free-standing Psychiatric Hospitals
  - Free-standing Inpatient Rehabilitation Hospitals

  AHA will NOT collect information from hospital owned freestanding SNFs at this time
- **Quarterly data collection to begin <u>after the permanent program rolls out and audits begin</u>**
- **Data entered into survey is protected by data use agreements**

American Hospital Association

Why AHA RACTrac?

- ✓ **Internally tracking RAC audit activity is essential for minimizing financial risk, identifying areas for improvement and surviving the RACs.**
  - *A claim management tool* will help you organize your data
- ✓ **Data on the impact of the RACs on hospitals is essential for AHA to be successful in our advocacy efforts.**
- ✓ **Hospital participation in *RAC*Trac will provide AHA and the State Hospital Associations the data they need to advocate on your behalf.**
- ✓ **Participation in *RAC*Trac will allow AHA to identify trends in reasons for denials across the RAC regions or at the national level. This information can be used to educate the field.**
- ✓ **RACTrac is FREE and available to hospitals that would like to provide data regardless of membership**

American Hospital Association

RACTrac Compatible Vendors

- **AHA is currently working with several vendors who have developed claim level RAC audit tracking tools and would like to make their tools RACTrac "compatible."**
- **A RACTrac compatible vendor will allow you to easily aggregate your RAC experience data and report it to AHA on a quarterly basis through www.aharactra.org**
- **Ask your vendor – Is your tool AHA RACTrac "compatible?"**
- **See the current vendor list at www.aha.org/rac under RACTrac**

American Hospital Association

Get Ready

- **AHA will start requesting data from hospitals in early 2009.**
- **Look for more reasources from AHA at www.aha.org/rac**

Questions

RACinfo@aha.org

American Hospital Association

APPENDIX B

RACTrac

INTRODUCTION

In May 2008, the Centers for Medicare & Medicaid Services (CMS) reported that Medicare Recovery Audit Contractors (RACs) — entities tasked with identifying government overpayments and underpayments — collected $980 million in overpayments from Medicare providers during fiscal years 2005-2008 as part of a five-state demonstration project. The majority of those dollars were recouped from the nation's hospitals.

Although the American Hospital Association (AHA) is urging CMS and Congress to make significant changes to the RAC program, the AHA and Georgia Hospital Association (GHA) are advising hospitals to prepare for RAC reviews now! Reviews will begin in some states as early as this summer (see CMS' RAC Web site at www.cms.hhs.gov for a detailed roll-out plan).

Hospitals should begin to prepare for RAC reviews by assembling an internal team to plan and implement process improvements to reduce RAC vulnerabilities. A self-audit to identify risks is an important first step. Once RAC audits begin, you should internally track any and all RAC activity to minimize your financial risk and ensure that you respond to the RACs in a timely fashion to avoid technical denials. A tracking system also will help you monitor the status of your claims in order to preserve your appeal rights on every claim that is identified as an overpayment.

In response to the lack of data and information provided by CMS and the RACs on the impact the program is having on America's hospitals, AHA has created ***RACTrac***, a web-based survey that will ask hospitals to report on a quarterly basis on their RAC experience.

Hospitals will need to organize their data to properly respond to the ***RACTrac*** survey. That is why the AHA also has created a basic Excel template to help you track your denials, claim by claim. You can find this template, along with other tools, on www.AHARACTrac.org when it goes live later this spring. Once you start using this template, or another you may have already created, you will be ready to provide data to AHA on a quarterly basis. All individual hospital data will remain confidential and only aggregate information will be shared when appropriate.

RACTrac will collect the following types of data:

- Number of claim denials and total dollars associated with over payments and underpayments;

- Service areas where overpayments are being identified (inpatient, outpatient, rehab etc.);
- Reasons for claim denials cited by the RACs;
- Number of appeals filed and the dollars associated with those appeals; and
- Quantifying administrative burden and costs by hours of staff dedicated to managing the RAC process and dollars paid to consultants.

Your organization's participation in *RACTrac* also will provide AHA and GHA with the critical data we need to successfully advocate on your behalf. ***RACTrac*** will allow us to identify trends in reasons for denials across regions and at the national level. This information will then be used to educate the field, CMS and Congress on changes needed to the program.

We anticipate RAC audits will begin in some states in the summer of 2008. Georgia hospitals will begin RAC audits in August 2009. ***RACTrac*** and its associated tools are now available. Information about how you can register can be found at www.AHARACTrac.org. Additional information about the RACTrac Program, provided courtesy of the American Hospital Association, is attached.

Inpatient Prospective Payment System Hospital and Long Term Care Hospital Review and Measurement Fact Sheet

Background

This fact sheet describes a change that is being made by the Centers for Medicare & Medicaid Services, with regard to the review of acute inpatient prospective payment (IPPS) hospitals and long term care hospitals (LTCHs). Medicare Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) will now conduct medical review to prevent improper payment of inpatient hospital claims. Medical review is the process performed by Medicare contractors to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act. In addition, the Comprehensive Error Rate Testing (CERT) contractor will now conduct medical review to measure inpatient hospital payment error rates.

Previously, in addition to their focus on quality issues, the Quality Improvement Organizations (QIOs)' responsibilities included the following for acute IPPS hospitals and LTCHs:

- The Hospital Payment Monitoring Program (HPMP), which was performed on a postpayment basis and consisted of 2 parts:
    1. Utilization review of randomly selected claims for payment purposes, and
    2. Measurement of the accuracy of Medicare Fee-for-Service (FFS) payments to acute IPPS hospitals and LTCHs (that is, the "error rate")
- Performance of provider-requested higher-weighted diagnosis related group (DRG) reviews;
- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases; and
- Performance of Expedited Determinations.

QIOs are no longer responsible for the functions previously included in the HPMP. They will retain responsibility for quality oversight in all Medicare FFS settings, provider-requested higher-weighed DRG reviews, EMTALA reviews, provider education on quality of care issues, and expedited determinations.

Rationale

CMS is making this change as part of its commitment to improving the efficiency and quality of health care delivered to Medicare beneficiaries. The transition of responsibility for measuring and preventing improper payments to inpatient hospitals from the QIOs to the FIs, MACs, and the CERT contractors will allow the QIOs to concentrate on improving patient quality of care and maintaining quality improvement and provider assistance efforts. This transition also aligns the oversight of acute IPPS hospital and LTCH claims with that of all other Medicare FFS provider types.

Timing
The transition is occurring in two phases:

- The CERT contractor began reviewing claims for the purpose of measuring error rates for acute IPPS hospital and LTCH claims on April 1, 2008.

- We anticipate FIs and MACs will begin reviewing acute IPPS hospital and LTCH claims, for the purpose of determining the appropriate payment due and preventing or reducing improper payments, this summer.

Hospitals will start receiving medical record requests from the CERT contractor in May, and FIs and MACs will begin requesting medical records later this summer.

Responsibilities

- The activities related to acute IPPS hospital and LTCH review that will now be performed by a different review entity are: FIs and MACs will perform medical review of acute IPPS hospitals and LTCH claims, on either a prepayment or post-payment basis, to ensure that they are for covered, correctly coded and reasonable and necessary services and will conduct claim adjustments, as appropriate, on claims which are not.

- FIs and MACs will conduct provider feedback, through their medical review departments, based on findings from medical review of acute IPPS hospital and LTCH claims. They will also continue to conduct provider education, through their provider outreach and education department, on issues related to submitting inpatient claims correctly as part of their goal to reduce the error rate.

- The CERT contractor will perform reviews on a post-payment basis, in order to determine the degree to which Medicare FIs and MACs are paying acute IPPS hospitals and LTCHs claims appropriately, in accordance with coverage, coding, and medical necessity guidelines.

These utilization reviews, provider education, and error rate measurements will be conducted in a manner consistent with that used by FIs, MACs, and the CERT contractor in the review and error rate measurement for all other Medicare fee-for-service (FFS) claims.

The activities related to acute IPPS hospital and LTCH claims review which will continue to be performed by the QIOs are:

- Quality of Care Reviews due to beneficiary complaints, complaints other than from beneficiaries, and quality of care reviews for cases referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG).

- Utilization reviews for Hospital requested higher-weighted DRGs;

- Utilization reviews referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG.) for cases involving issues such as transfers and readmissions;

- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases;

- Expedited determinations; and

- Provider education on quality of care issues, and other issues under their purview (e.g. hospital-requested higher weighted DRG review, etc.).

Claim Review Process

The coverage and payment guidelines used by the FIs, MACs and CERT contractor will be the same as used in the past by the QIOs, though some claim selection and review procedures will be different.

Notification and Record Submission:

The hospital will know when a claim has been selected for review in slightly different ways, depending on the review entity. For purposes of measuring the error rate, the CERT Contractor will notify providers that claims have been selected for CERT review via letter or telephone contact.

- The medical record request letter will be mailed or faxed according to the hospital's preference.
- Hospitals may submit medical records via mail or fax.

For prepay review, the FIs and MACs will suspend claims for review and the FIs and MACs will then send out a request for supporting documentation. Providers may use the claim inquiry screen in the Direct Data Entry (DDE) system and verify the status of the claim. They may view the narrative for the reason code that is applied to a suspended claim. The narrative will provide the reason for the suspension. Hospitals submit hardcopy medical records via mail.

For postpay review, the claim is already paid. An FI or MAC performing postpay review will send a request for medical records to the provider. The FIs or MACs will review the claim and make any adjustment necessary to the claim based on the review. Hospitals submit hardcopy medical records via mail.

Screening and Review:

Most QIOs used a commercial screening tool as a first-level indicator of the appropriateness of the services billed, though they were not required to use a particular tool. FIs, MACs and the CERT contractor are also required to use screening criteria in the review of acute IPPS hospital and LTCH claims, though, as was true for the QIOs, CMS is not mandating the use of a particular tool.

In addition to use of a screening tool, FIs, MACs, and the CERT contractor will apply coverage, coding, and medical necessity guidelines, utilizing clinical judgment in making payment determinations on each claim, as the QIOs did.

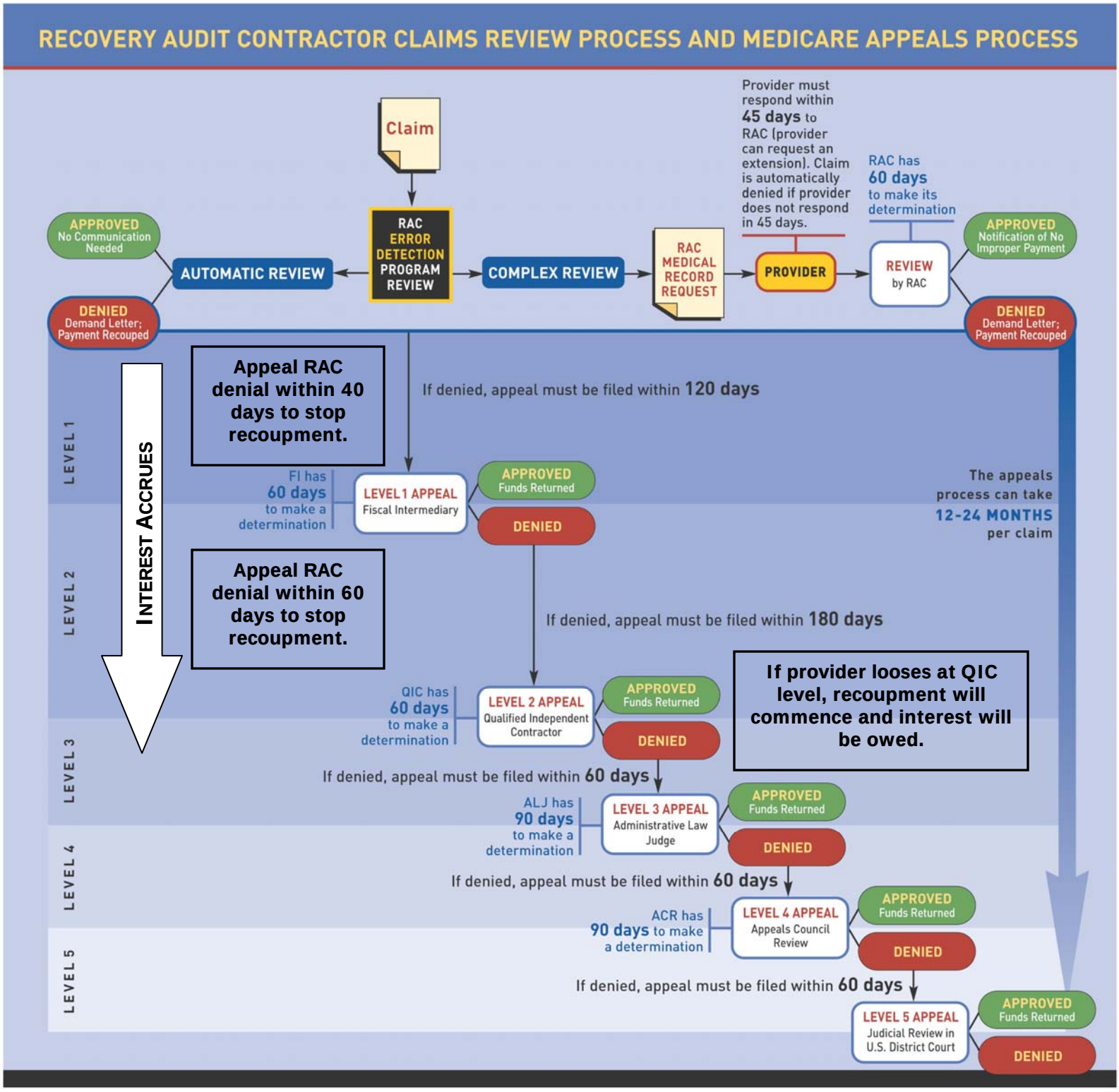
Reviewers:
Qualified clinicians, such as nurses and therapists, will perform the reviews, consulting with physicians or other specialists as needed. As is the case with all other Medicare claim types reviewed by FIs, MACs, and the CERT contractor, there is no CMS requirement that physicians be used to review each acute IPPS hospital and LTCH claim on which an adjustment may be made.

Comparison Chart
Because of varying statutory requirements, there are some differences in the claim review processes used by various review entities. The following chart provides a comparison of the processes used by the QIOs, CERT contractor, FIs, and MACs.

Side-by-Side Contractor Activity Comparison Chart

Issue	QIOs (HPMP)	CERT	FIs/MACs
Review selection	Random	Random	Targeted to claims with suspected improper payments. Initially, there may be some random review.
When the claim is selected for review	Postpayment: 3 months after discharge	Postpayment: Medical record request letter sent ~ 35 days after payment	Prepayment: Shortly after the claim is submitted or Post payment: Up to 4 years after payment
Credentials of reviewers	Qualified clinicians	Qualified clinicians	Qualified clinicians
Level of physician involvement in review process	Review all claims where nonphysician reviewer identifies a problem with the claim	As needed for complex cases	As needed for complex cases
Use of coding experts	Mandatory	Mandatory	Mandatory
Distribution of Program for Evaluating Payment Patterns Electronic Report (PEPPER	Mandatory	N/A	Undetermined

Issue	QIOs (HPMP)	CERT	FIs/MACs
Report) This is a report containing hospital specific data for fourteen Diagnosis Related Groups (DRG) and discharges that have been identified as high risk for payment errors for every hospital in a QIOs state.			
Use of web-based application that allows providers to customize address & contact information	No	Yes	Future web based application would allow providers to see and update their practice location.
Reimbursement for photocopying medical records	Yes	No	No
Where to file initial appeal	QIO	FI or MAC	FI or MAC



Notes: Draft July 2, 2008
This process illustrates how the DEMONSTRATION RACs operated. This process is subject to change. In addition CMS has issued Transmittals 314 and 322 administratively updating the Medicare Appeals process as indicated by the additional text boxes. This graphic is illustrative only and does not take into account the RAC Rebuttal process or any additional changes that may occur in the permanent program.

American Hospital Association

Regulatory Advisory

July 16, 2008

MEDICARE RECOVERY AUDIT CONTRACTORS (RACS): CODING & DOCUMENTATION STRATEGIES

AT A GLANCE

The Issue:

The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. The Centers for Medicare & Medicaid Services (CMS) recently reported that RACs collected $992.7 million in overpayments during the three-year RAC demonstration, with more than 96 percent of these funds collected from hospitals in a limited number of states. Thirty-five percent of RAC denials were due to incorrect coding, while another 8 percent were due to insufficient or no documentation.

Our Take:

Since coding and documentation errors accounted for nearly half (43 percent) of RAC demonstration denials, we anticipate that these types of errors will be targeted by the permanent RACs, and encourage you to focus on these particular types of errors in your preparations for the national RAC rollout. The AHA has many concerns about the RAC program and is working with CMS and Congress to improve RAC oversight and fairness. Still, it is important for hospitals to prepare, as hospitals have a valuable opportunity to proactively ensure the accuracy of their documentation and coding practices to reduce the risk of significant RAC denials.

What You Can Do:

This advisory highlights the types of coding issues targeted during the RAC demonstration and strategies your organization can implement to reduce the impact of RAC audits. It also outlines steps your hospital can take to improve medical record documentation.

This information is provided only as a guideline. Consult with legal counsel and your financial and coding experts before finalizing any policy or practice.

Please share this advisory with the following key staff:

- Your executive, medical and financial leaders, and legal counsel;
- Your RAC team, which should include physicians, nurses, case managers and others making clinical decisions on documentation; and
- Coding, billing and documentation specialists, as well as medical records/health information management staff.

Further Questions:

Please contact Nelly Leon-Chisen, RHIA, AHA director of coding and classification, at (312) 422-3396 or email nleon@aha.org.

AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A seven-page, in-depth examination of this issue follows.

American Hospital Association

Regulatory Advisory

July 16, 2008

MEDICARE RECOVERY AUDIT CONTRACTORS (RACS): CODING AND DOCUMENTATION STRATEGIES

BACKGROUND

The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments – to providers. Following a three-year RAC demonstration, which ended March 2008, the Centers for Medicare & Medicaid Services (CMS) plans to expand the program nationwide through a three-stage process, with 19 states coming under RAC review this summer, followed by five states in the fall, and the remaining states beginning in 2009. (A map of the projected roll-out dates is available at http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.) RACs will review claims that are up to three years old, but in no case may review claims paid prior to October 1, 2007. Therefore, it is imperative that hospitals do everything possible to prepare for RAC review to avoid potentially disruptive claims denials.

CMS recently reported that RACs collected $992.7 million in overpayments from Medicare providers during the RAC demonstration, with more than 96 percent of these funds collected from hospitals. Thirty-five percent of denials were due to incorrectly coded claims and 8 percent were for insufficient or no documentation. To minimize coding and documentation denials, hospitals must ensure that key staff understand the importance of accurate clinical coding and provide staff with necessary resources, such as the most recent coding guidelines for the areas targeted by the demonstration RACs.

During the demonstration, each of the three RACs had the autonomy to unilaterally identify the types of claims and errors they targeted. The following coding areas were targeted by one or more RACs during the demonstration and are addressed in greater detail below:

- Debridement (excisional vs. nonexcisional);
- Incorrect selection of principal diagnosis (respiratory failure vs. sepsis);
- Wrong diagnosis code (sepsis, septicemia vs. urosepsis);
- Diagnosis-related groups (DRGs) designated as complicated or having comorbidity with only one secondary diagnosis (DRGs 079, 416, 468, 475, 477 and 483); and
- Unit of service (multiple colonoscopies for the same beneficiary on the same day; Neulasta, 1 unit per vial vs. 1 unit per milligram of drug delivered).

We anticipate that these coding areas will be among the early targets for the national RAC program, although CMS has indicated that it will have more oversight of the types of audits selected by the new permanent RACs.

AT ISSUE

Coding and Documentation Recommendations

The following strategies will help your hospital ensure accurate coding and medical record documentation. An emphasis on both documentation and coding is critical to minimize your risk for RAC denials. Without consistent and complete documentation in the medical record, accurate coding cannot be achieved. While your hospital already may have many of the processes below in place, given the high rate of RAC demonstration denials for documentation and coding errors, we encourage you to revisit your policies and practices to help reduce your hospital's RAC denials.

- Examine your clinical documentation protocols to identify areas for improvement.
  - Provider documentation must support every coding assignment. Per the coding guidelines, "provider" means physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.
  - Review and refine your process for identifying potential gaps in each record's documentation that may require additional physician specificity.
  - Review and refine your physician query process according to the do's and don'ts developed by the American Health Information Management Association (AHIMA)[1], which provide guidelines on obtaining physician clarification on missing information or inconsistent documentation.
  - Review coding and documentation guidelines with outside consultants and vendors to stress the importance of the accuracy and integrity of medical record documentation and coding.
  - Review your charge description master (CDM) and ensure that the unit of service for HCPCS codes is correctly identified (e.g., grams vs. milligrams).
- Work with your physicians, nurses and other clinicians to ensure a consistent and collaborative approach on your hospital's coding and documentation protocols.
  - Develop and periodically update facility-specific coding guidelines that promote the complete documentation needed for consistent code assignment.
  - Develop guidelines to clarify when coding professionals should query physicians for clarification of their documentation.
  - Emphasize that coding guidelines must be applied to all records.
  - Emphasize that facility-specific coding guidelines do not replace the need for provider documentation.

[1] Physician query "do's and don'ts" are included in the AHIMA document "Practice Brief: Developing a Physician Query Process," available at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_009224.hcsp?dDocName=bok1_009224.

- Provide adequate resources and support for your coding professionals.

  - Provide current changes, coding advice and official coding guidelines to ensure correct code selection based on the rules applicable at the time of discharge.
  - Provide the following reference tools:
    - *Official Guidelines for Coding and Reporting.*
    - Current coding references (ICD-9-CM, CPT, HCPCS coding manuals or encoder).
    - *AHA Coding Clinic for ICD-9-CM.*
    - *AHA Coding Clinic for HCPCS.*
    - *CPT Assistant.*
  - Be sure coders and medical staff are familiar with the definitions of principal diagnosis and secondary diagnoses.
  - Conduct periodic meetings to review problem documentation areas, staff resources and determine whether revisions to Physician Query Forms are needed to streamline the process.
  - Provide regular training and continuing education for coders.

- RAC-specific recommendations:

  - Develop an internal tracking system to track all RAC communications and monitor the status of RAC record requests, records submitted for review, audit outcomes, and appeals activity.
  - Select a RAC coordinator to manage all RAC inquiries, coordinate evaluation of all medical records sent out for RAC review, and document and track all RAC communication.
  - Educate staff (i.e., clinicians, HIM coders, billers, financial managers, clinical documentation specialists, etc.) about the RAC.
  - Conduct internal (retrospective) coding audits to uncover potential problem areas.
  - Identify a process for reviewing RAC coding denials to determine validity of RAC denials.
    - Implement additional training of coders in RAC target areas.
    - Determine a process for appealing inappropriate RAC coding and documentation denials.

Recommendations for Coding Professionals

The following recommendations are intended for hospital personnel conducting medical record coding.

- The entire medical record should be reviewed to determine the specific reason for the encounter and the conditions treated.
- Abnormal findings (laboratory, X-ray, pathologic and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance.

- Do not assign diagnosis codes based on a patient's signs or symptoms without confirmation from the provider.
- Suspected "probable," "possible" and "rule out" diagnoses are coded as present for inpatient admissions, but only if the diagnosis is still not ruled out at the time of discharge.
- Assign codes for all diagnoses meeting the criteria for reportable diagnoses as identified in the *Official Guidelines for Coding and Reporting*.
- Keep current with changes in codes, coding advice and official coding guidelines to ensure correct code selection based on the rules applicable at the time of discharge.

Coding Clinic Guidelines for Codes Targeted during RAC Demonstration

Debridement. Many claims that were coded as excisional debridement (86.22) were denied during the RAC demonstration due to insufficient documentation regarding the type of debridement performed (excisional vs. nonexcisional), or due to code selection based on documentation available (e.g., sharp debridement coded as excisional debridement). Many of these denials were appealed by hospitals during the demonstration program and many cases are still unresolved. However, additional review of the following guidelines is important to ensure your hospital is coding correctly.

- Debridement of Amputation Site, *Coding Clinic,* First Quarter 2005 Page: 14.
- Debridement of amputation stump, *Coding Clinic,* Second Quarter 1998 Page: 15.
- Debridement of open fracture with fixation and shortening, *Coding Clinic,* Third Quarter 1995 Page: 12.
- Debridement of wound, excisional vs. nonexcisional – *Coding Clinic,* Fourth Quarter 1988.
- Escharotomy, *Coding Clinic,* Fourth Quarter 2000 Page: 68.
- Excisional Debridement, *Coding Clinic,* First Quarter 2008 Pages: 3 – 4.
- Excisional Debridement, *Coding Clinic,* Fourth Quarter 2004 Page: 138.
- Excisional Debridement of Other Sites, *Coding Clinic,* Second Quarter 2005 Pages: 3 – 4.
- Excisional debridement of wound, *Coding Clinic*, Second Quarter 2000 Page: 9.
- Excisional vs. nonexcisional debridement – guideline, Coding Clinic, Third Quarter 1991 Pages: 18 – 19.
- Extensive wound debridement, Coding Clinic, First Quarter 1999 Pages: 8 – 9.
- Laser debridement of ulcer down to bone w/skin flap closure, *Coding Clinic,* Second Quarter 1992 Page: 17.
- Laser debridement of wound down to bone, *Coding Clinic,* Third Quarter 1989 Page: 16.
- Nonsurgical Mechanical Debridement, *Coding Clinic,* Second Quarter 2004 Page: 6.
- Oasis (TM) wound dressing, *Coding Clinic,* Third Quarter 2002 Page: 23.
- Sharp Debridement Versus Excisional Debridement, *Coding Clinic,* Second Quarter 2004 Page: 5.
- Vacuum Assisted Closure (VAC), *Coding Clinic,* Third Quarter 2006 Pages: 19 – 20.

Sepsis, septicemia. During the RAC demonstration, many sepsis claims were denied because of incorrect sequencing of codes or insufficient documentation to support the diagnosis of sepsis. It is important to note that there are two different codes for urosepsis, and code selection should reflect the patient's condition and care, as documented in the medical record. For example, documentation supported urosepsis, meaning urinary tract infection (a localized infection), but the claim was coded for urosepsis meaning sepsis (systemic infection).

- *Official Guidelines for Coding and Reporting,* Section I, C, 1, b.
- Bacteremia – guidelines, *Coding Clinic,* Fourth Quarter 1993 Pages: 29 – 30.
- Bacteremia vs. septicemia, *Coding Clinic*, Second Quarter 2000 Page: 5.
- Biliary sepsis due to percutaneous transhepatic cholangiogram, *Coding Clinic,* Second Quarter 1995.
- Changes to the Official Guidelines for Coding and Reporting, *Coding Clinic,* Fourth Quarter 2003 Pages: 113 – 115.
- Clarification - Sepsis Due to Vascular Catheter, *Coding Clinic,* Second Quarter 2004 Page: 16.
- Clinical evidence of septicemia, *Coding Clinic,* Second Quarter 2000 Page: 3.
- Infection Due to Vascular Catheter, *Coding Clinic,* Fourth Quarter 2007 Pages: 96 – 97.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic,* Fourth Quarter 2007 Pages: 142 – 151.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic,* Fourth Quarter 2006 Pages 152 – 160.
- Influenza, Pneumonia, Septic Shock and Multi-Organ Failure, *Coding Clinic,* Second Quarter 2005.
- Nadir sepsis, *Coding Clinic,* Third Quarter 1996 Page: 16.
- Neutropenic sepsis, *Coding Clinic,* Second Quarter 1996 Page: 6.
- Sepsis syndrome, *Coding Clinic,* Second Quarter 2000 Pages: 3 – 4.
- Septic shock, *Coding Clinic,* Fourth Quarter 2003 Page: 7.
- Septic Shock, Respiratory Failure and Pneumonia, *Coding Clinic,* Second Quarter 2005 Pages: 19 – 20.
- Septicemia and septic shock – guidelines, *Coding Clinic,* First Quarter 1988.
- Septicemia diagnosis with negative blood cultures, *Coding Clinic,* Third Quarter 1988.
- Septicemia due to candida albicans, *Coding Clinic,* Second Quarter 1989 Page: 10.
- Septicemia due to staphylococcus, *Coding Clinic,* Fourth Quarter 1997 Page: 32.
- Septicemia due to vascular access device (VAD), *Coding Clinic,* Second Quarter 1994 Page: 13.
- Septicemia with negative blood cultures, *Coding Clinic,* Second Quarter 2000 Page: 5.
- Septicemia, SIRS, sepsis, severe sepsis and septic shock, *Coding Clinic,* Fourth Quarter 2003 Pages: 79 – 81.

- Systemic inflammatory response syndrome, *Coding Clinic,* Fourth Quarter 2002 Pages: 71 – 73.
- Urosepsis, *Coding Clinic,* First Quarter 1998 Page: 5.
- Urosepsis, organ specific sepsis, *Coding Clinic,* Second Quarter 2000 Page: 6.

Urosepsis. Some claims were denied by RACs because documentation in the record supported urosepsis, meaning urinary tract infection, but the Medicare claim was coded for urosepsis, meaning sepsis (systemic infection).

- *Official Guidelines for Coding and Reporting,* Section I, C, 1, b.
- Infectious and Parasitic Diseases, *Coding Clinic,* First Quarter 2006 Pages: 34 – 40.
- Infectious and Parasitic Diseases, *Coding Clinic,* First Quarter 2005 Pages: 34 – 40.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic,* Fourth Quarter 2007 Pages: 142 – 151.
- Infectious and Parasitic Diseases (001-139), *Coding Clinic,* Fourth Quarter 2006 Pages 152 – 160.
- Septicemia, SIRS, sepsis, severe sepsis and septic shock, *Coding Clinic,* Fourth Quarter 2003 Pages: 79 – 81.
- Urosepsis, *Coding Clinic,* First Quarter 1998 Page: 5.
- Urosepsis, *Coding Clinic,* Second Quarter 2004 Page: 13.
- Urosepsis, organ specific sepsis, *Coding Clinic,* Second Quarter 2000 Page: 6.

Respiratory Failure. Some claims were denied for incorrect sequencing of principal diagnosis – respiratory failure vs. sepsis.

- *Official Guidelines for Coding and Reporting,* Section I, C, 1, b.
- *Official Guidelines for Coding and Reporting,* Section I, C, 8, c.
- Acute Respiratory Failure and Myasthenia Gravis, *Coding Clinic,* Fourth Quarter 2004 Page: 139.
- Acute respiratory failure due to mycoplasma pneumonia, *Coding Clinic,* November - December 1987 Pages: 5 – 6.
- Acute Respiratory Failure Due to Poisoning, *Coding Clinic,* Third Quarter 2007 Pages: 7 – 8.
- Burns and Respiratory Failure Due to Smoke Inhalation, *Coding Clinic,* Third Quarter 2005 Pages: 10 – 11.
- Carcinoma of the oropharynx with impending respiratory failure, *Coding Clinic,* Second Quarter 2002 Page: 6.
- Clarify - respiratory failure with respiratory conditions, *Coding Clinic,* Second Quarter 2000 Page: 21.
- Crack overdose with respiratory failure, *Coding Clinic,* First Quarter 1993 Page: 25.
- Diseases of Respiratory System, *Coding Clinic,* Fourth Quarter 2006 Pages 177 – 179.

- Diseases of Respiratory System (460-519), *Coding Clinic,* Fourth Quarter 2007 Pages: 167 – 170.
- Hypoxemia with Pneumonia and/or Respiratory Failure, *Coding Clinic,* Second Quarter 2006 Pages: 24 – 25.
- Respiratory Failure, *Coding Clinic,* First Quarter 2005 Pages: 3 – 8.
- Respiratory failure – acute or chronic, *Coding Clinic,* Fourth Quarter 1998 Page: 41.
- Respiratory failure – blood gas measurement, *Coding Clinic,* Second Quarter 1990 Pages: 20 – 21.
- Respiratory failure – clarification, *Coding Clinic,* Second Quarter 2003 Pages: 21 – 22.
- Respiratory failure – guidelines, Coding Clinic, September – October 1987.
- Respiratory failure – guidelines, *Coding Clinic,* Third Quarter 1988 Page: 7.
- Respiratory failure due to Pneumocystis carinii due to AIDS, *Coding Clinic,* First Quarter 2003 Page: 15.
- Respiratory failure due to poisoning – sequencing, *Coding Clinic,* Third Quarter 1991 Page: 14.
- Respiratory failure w/ nonrespiratory conditions – guidelines, *Coding Clinic,* Second Quarter 1991 Pages: 3 – 5.
- Septic Shock, Respiratory Failure and Pneumonia, *Coding Clinic,* Second Quarter 2005 Pages: 19 – 20.

NEXT STEPS

Please share this advisory with your hospital leadership, RAC team and all clinical, coding and billing staff involved with medical record documentation and coding. We suggest you revisit and implement those documentation and coding strategies that your organization is not already using to prepare for the national RAC program. Watch for additional member education calls and advisories from the AHA in the coming months as the national RAC program is implemented.

American Hospital Association

RAC UPDATE

Prepared for state, metropolitan and regional hospital associations.
(This report is one page.)

Status Report on Recovery Audit Contractors

August 1, 2008

Latest RAC News

- On July 11, CMS released its evaluation report on the Recovery Audit Contractor Demonstration. While the report outlines many improvements that will be made in the permanent program, it did not fully account for thousands of RAC appeals that are still in process. CMS said it will periodically update the report to reflect the most current status of RAC appeals. We expect the first update in August, which should reflect RAC appeals data through June 30, 2008.

- CMS has also further postponed the naming of the permanent RAC contractors until September 2008. This will further delay rollout to the 20 states selected for the first stage of the national RAC program. Given these time frames, review activity should be minimal before year-end.

- CMS is still developing its policy on a RAC medical record request limit. AHA has recommended a sliding scale limit based on Medicare volume with smaller hospitals having a lower cap than larger hospitals. Based on discussions with associations in the demonstration states, we've recommended a maximum of 50 medical records per National Provider Identifier (NPI) in a 45-day period and no more than 200 records per tax identification number for organizations with multiple NPIs. As we learn more we will keep you informed.

- CMS has indicated that it plans to delay implementation of a new policy that allows providers to keep their payments during the appeals process. In June, AHA sent a Special Bulletin regarding two Transmittals issued by CMS that would amend the current Medicare Appeals Policy and allow a provider to stop the recoupment of dollars identified by the RACs and other Medicare contractors if an initial appeal to the Fiscal Intermediary or Medicare Administrative Contractor was filed by the provider within 40 days. CMS originally indicated that the new policy would be implemented on July 7. AHA is working to get clarification on this process and timing of the delayed implementation.

AHA RAC Resources

The RAC demonstration report, AHA's Special Bulletin on the report, the rollout map, and other RAC information are available at www.aha.org/rac. For further questions, contact Rochelle Archuleta or Alyssa Keefe at (202) 638-1100, or e-mail RACinfo@aha.org

American Hospital Association

SPECIAL BULLETIN

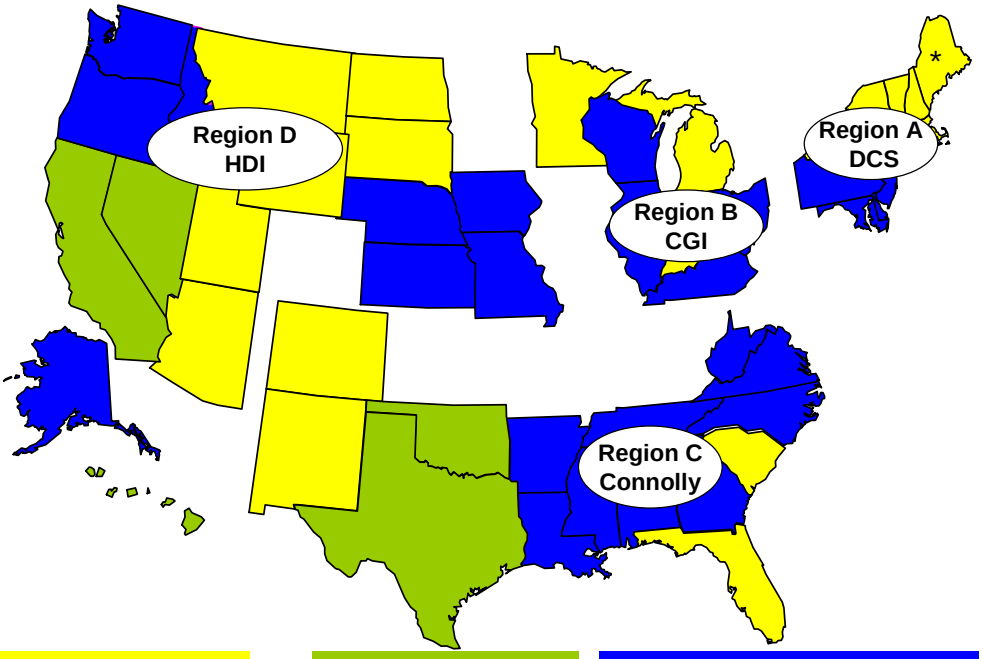
Wednesday, February 11, 2009

Medicare Recovery Audit Contractor Program – Back on Track

As we reported last week, the Centers for Medicare & Medicaid Services (CMS) on February 6 announced that two companies that unsuccessfully bid to become Medicare recovery audit contractors (RACs) had withdrawn their bid protests, allowing the Medicare RAC program to proceed. The protests, filed last November, had placed a temporary hold on all RAC-related activities. CMS also announced that the two companies will serve as subcontractors to the four permanent RACs named last year. As a result, CMS is taking steps to resume its rollout of the permanent RAC program.

In recent discussions with the AHA, CMS provided additional details pertaining to implementation of the program. The map below depicts a revised, two-stage program rollout.

RAC Phase-In Schedule



***VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. Part B claims in RI will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.**

Due to the delay in implementing the program, the rollout has been shortened from a three-stage process to a two-stage process, as depicted above. CMS will begin the rollout in March with RAC preparation activities and, in March and April, CMS, the RACs and the state hospital associations will host RAC education sessions specifically targeted to hospitals. RAC audit activity is then expected to begin in May.

RACs will be required to complete several administrative actions prior to conducting audits. These include: receiving and processing CMS claims data; entering into joint operating agreements with the claims processing contractors in each state, such as CMS-contracted fiscal intermediaries and Medicare administrative contractors (MACs); and requesting CMS approval through the "new issue review process," which grants authority for widespread automated or medical necessity review, on a per RAC basis and for each type of claim to be targeted for review.

As reported, the four permanent RACs will collaborate with two subcontractors – PRG-Schultz USA, Inc. and Viant Payment Systems, Inc. Their subcontractor duties will include the following:

- ***Viant.*** As a subcontractor to Connolly Consulting, the RAC for Region C, Viant will conduct complex reviews of hospital inpatient claims and physician-administered J-codes in North Carolina, South Carolina, Virginia and West Virginia.
- ***PRG-Schultz***. PRG Schultz will act as a subcontractor to Diversified Collection Services (Region A), CGI (Region B) and HealthDataInsights (Region D). In this capacity, PRG Schultz will audit Part A/B MAC claims in, Maine, New Hampshire, Vermont, Minnesota, Wisconsin, Idaho, Oregon, and Washington; home health claims in Regions A, B and D; and durable medical equipment claims in Region B.

We urge you to begin preparing for RAC audit activity now. The AHA will update you as we learn more about the revised timeline and implementation of the permanent RAC program.

For more information on the RAC program, visit www.aha.org/rac. If you have further questions, please e-mail RACInfo@aha.org.

APPENDIX C

TABLE OF CONTENTS

C. Connolly & Associates Presentations

- RAC Region C – Kickoff
- RAC Region A

- **RAC Region C – Kickoff**

Connolly Consulting
CMS Region C RAC

Christine Castelli, Principal
Client Relations/Quality Assurance

October 23, 2008

Connolly Background

- Established in 1979 with a singular focus on recovery auditing
- Pioneered the use of data mining technology to identify and recover overpayments and underpayments
- Serves Medicare and Medicaid, and some of the industry's largest commercial payers
- Reviewed over $140 billion in paid medical claims in 2007

Connolly RAC Program Mission…

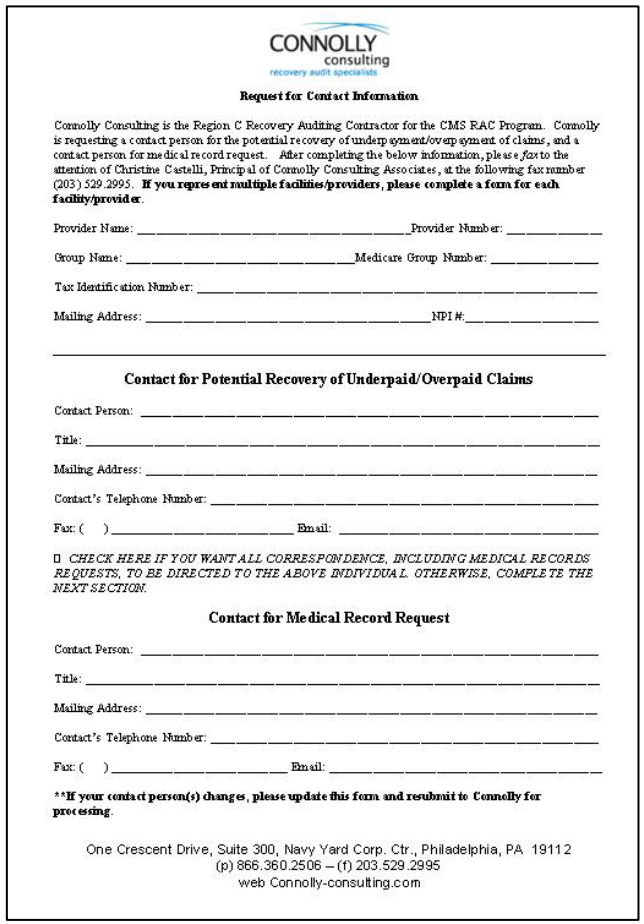
- Detect and correct Medicare past improper payments
- Analyze root causes of those improper payments and provide actionable process improvement recommendations to CMS that prevent or mitigate future improper payments
- Operate with high sensitivity to provider relations

Connolly Review Process

- Use same Medicare policies as FIs, Carriers and MACs: NCDs, LCDs, CMS manuals
- Use same types of staff as FIs, Carriers and MACs: nurses, therapists, certified coders and physician CMD

Get Prepared & Organized

- Complete, submit, and keep current your Request for Contact Information form



CONNOLLY consulting
recovery audit specialists

Request for Contact Information

Connolly Consulting is the Region C Recovery Auditing Contractor for the CMS RAC Program. Connolly is requesting a contact person for the potential recovery of underpayment/overpayment of claims, and a contact person for medical record request. After completing the below information, please *fax* to the attention of Christine Castelli, Principal of Connolly Consulting Associates, at the following fax number (203) 529.2995. **If you represent multiple facilities/providers, please complete a form for each facility/provider.**

Provider Name: _____ Provider Number: _____

Group Name: _____ Medicare Group Number: _____

Tax Identification Number: _____

Mailing Address: _____ NPI #: _____

Contact for Potential Recovery of Underpaid/Overpaid Claims

Contact Person: _____

Title: _____

Mailing Address: _____

Contact's Telephone Number: _____

Fax: ( ) _____ Email: _____

☐ *CHECK HERE IF YOU WANT ALL CORRESPONDENCE, INCLUDING MEDICAL RECORDS REQUESTS, TO BE DIRECTED TO THE ABOVE INDIVIDUAL. OTHERWISE, COMPLETE THE NEXT SECTION.*

Contact for Medical Record Request

Contact Person: _____

Title: _____

Mailing Address: _____

Contact's Telephone Number: _____

Fax: ( ) _____ Email: _____

****If your contact person(s) changes, please update this form and resubmit to Connolly for processing.**

One Crescent Drive, Suite 300, Navy Yard Corp. Ctr., Philadelphia, PA 19112
(p) 866.360.2506 – (f) 203.529.2995
web Connolly-consulting.com

Prepared & Organized, cont…

- Identify and maintain a RAC Liaison to manage correspondence
- Respond to RAC medical record requests fully and within the required 45 day turn around
- Communicate, communicate, and communicate

Connolly Resources

- Connolly RAC toll free phone number:
  866.360.2507
- Connolly RAC fax number:
  203.529.2995
- Connolly website:
  www.connollyhealthcare.com
- Connolly RAC office address:
  The Navy Yard Corporate Center
  One Crescent Drive, Suite 300
  Philadelphia, PA 19112
- Christine Castelli - 203.529.2315
  Christine.Castelli@connollyhealthcare.com

- **RAC Region A**

Medicare Recovery Audit Contractors (RACs):

An Introduction to the RAC Program

Ebony Brandon, MPA
Region A Project Officer

Lt. Gia Lawrence, RN
Region A Project Officer

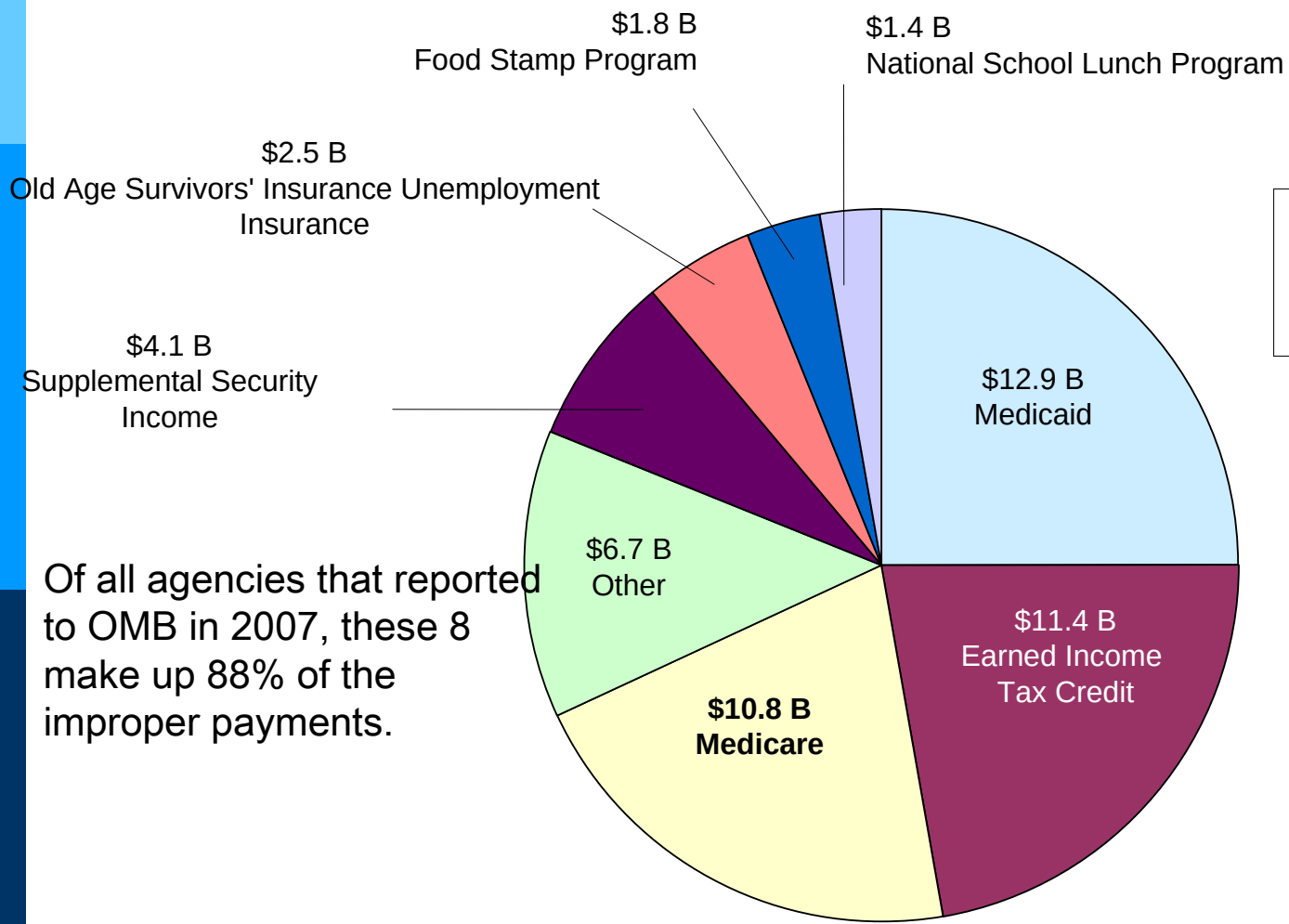
Outline

- **Background**
- **RAC Process**
- **Keys to Success**
- **What Providers Can Do to Get Prepared**

Background: IPIA

- **The Improper Payment Information Act requires federal agencies to measure and reduce improper payment rates**
- **"Improper payments" include:**
  - **Overpayments**
  - **Underpayments**

Background: Top 8 Federal Programs with Improper Payments



Medicare receives over 1.2 billion claims per year.

This equates to:

- 4.5 million claims per work day

Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.

Background: RAC Legislation

- Medicare Modernization Act Section 306:
  - required RAC demonstration

- Tax Relief Act and Healthcare of 2006, Section 302:
  - requires permanent and nationwide RAC program by no later than 2010

Both statutes gave CMS the authority to pay RACs on a contingency fee basis.

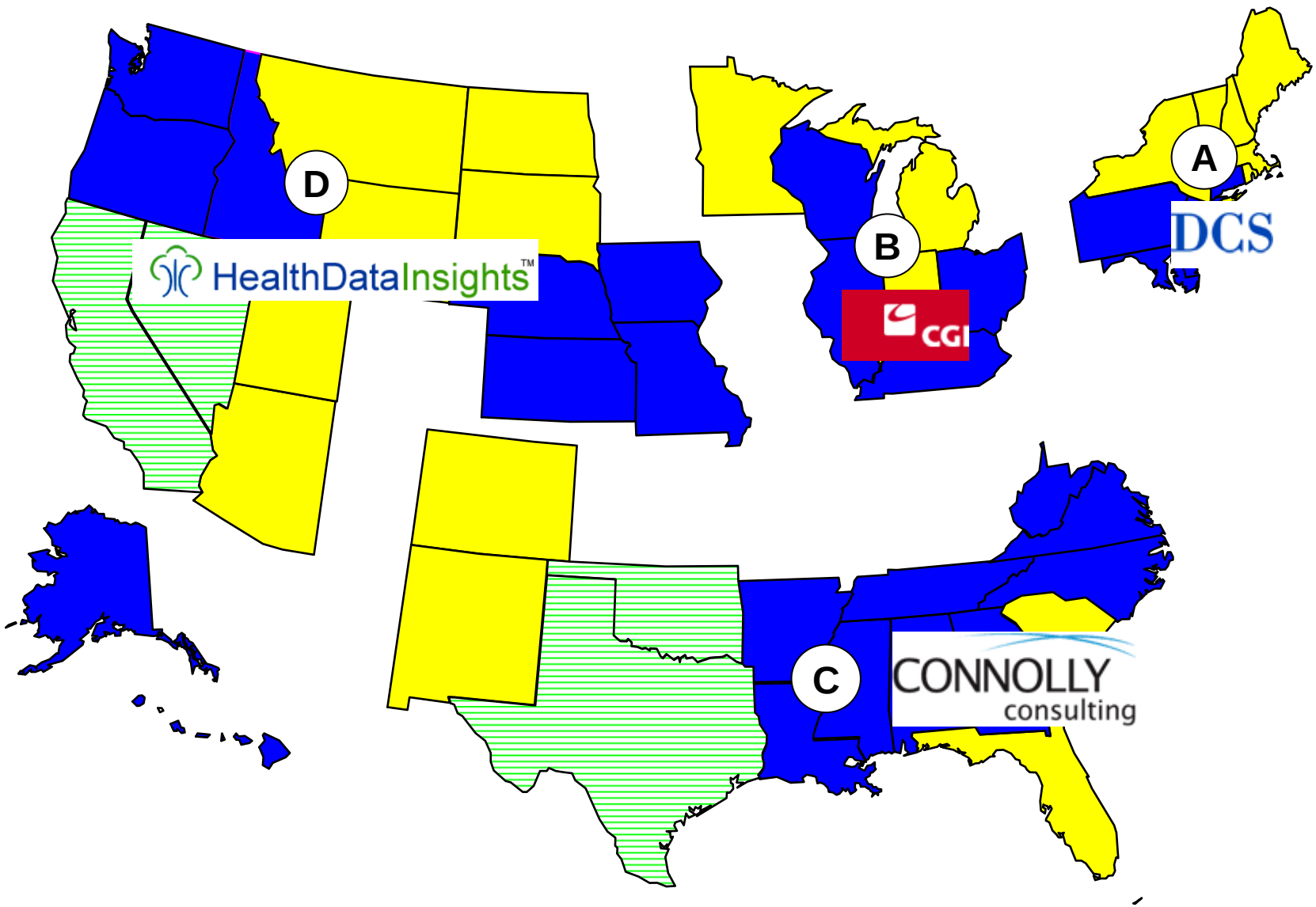
Background: RAC Program Mission

- The RACs detect and correct past improper payments so that
- CMS and the Carriers/FIs/MACs can implement actions that will prevent future improper payments.
  - **Providers** can avoid submitting claims that don't comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** & future Medicare beneficiaries are protected

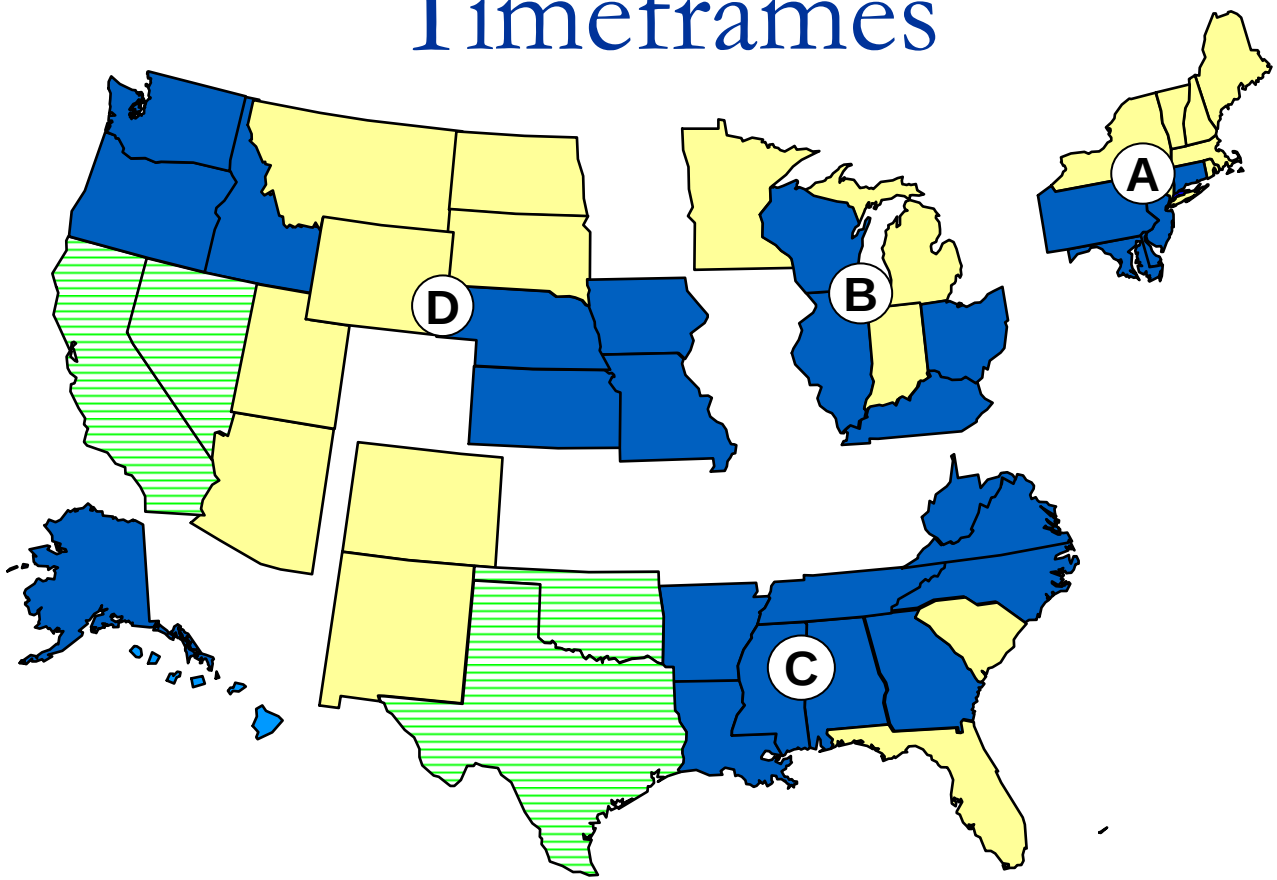
Background: Demonstration RACs

- Demonstration ran from March 2005-March 2008 in Florida, California, New York (was expanded in July 2007 to South Carolina & Massachusetts)
- CMS gave RACs $317 Billion in paid claims
- Demo RACs found $1 Billion in improper payments
- Demo RACs repaid $37 million to providers
- Only 6.8% of Demonstration RAC determinations were overturned on appeal (as of 6/30/08)

RAC Jurisdictions



Timeframes



Claims Available for Analysis	Provider Outreach	Earliest Correspondence
Oct 15, 2008	Nov 2008	Dec 1, 2008
Jan 15, 2009	Feb 2009	Mar 1, 2009
Jun 15, 2009	Jul 2009	Aug 1, 2009

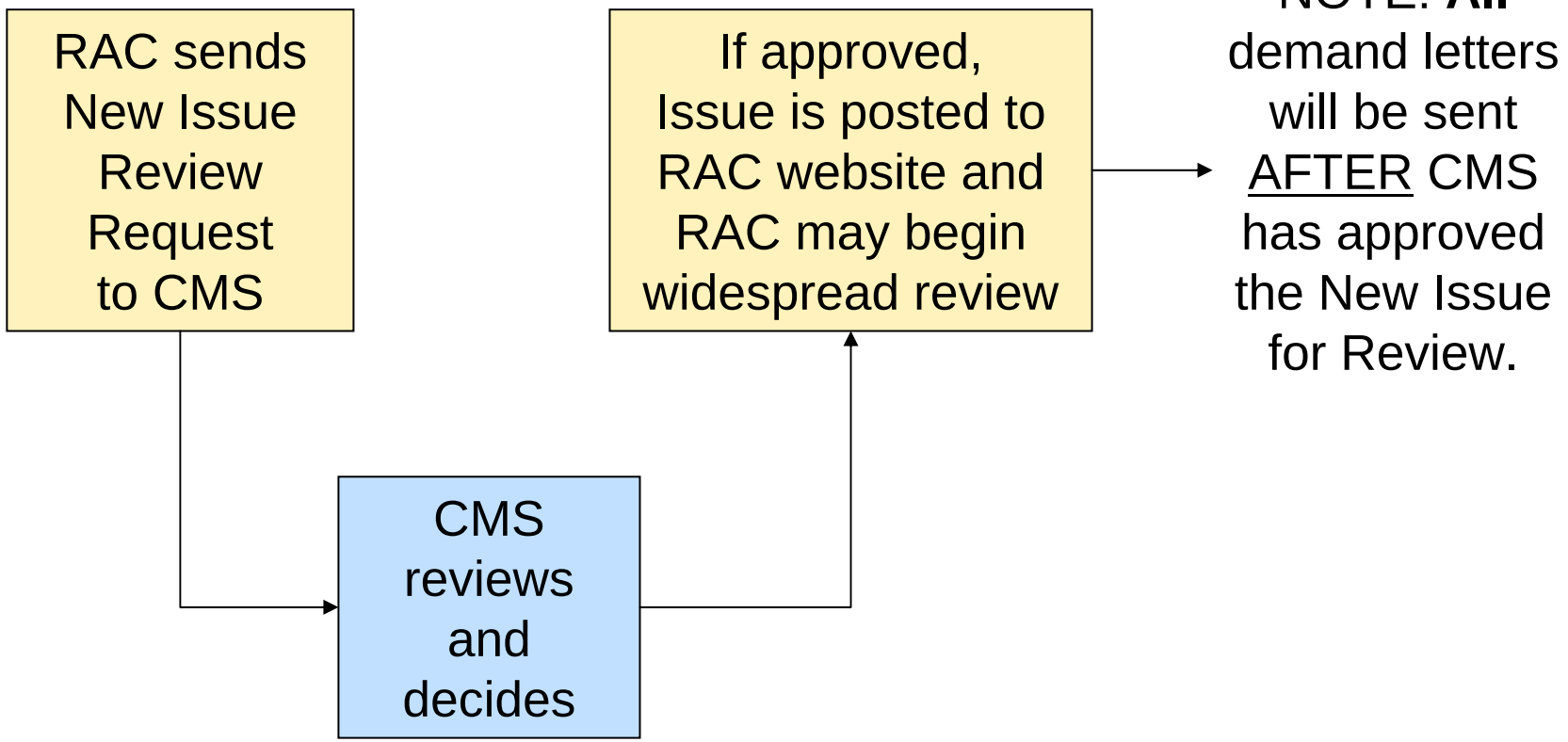
Selecting Claims

- RACs choose claims/issues to review based on data mining techniques, OIG & GAO reports, CERT reports and the experience and knowledge of staff
- Two types of review
  - Automated (no medical record)
  - Complex (medical records)
- New Issues for review will be posted to RACs website before widespread review
- RACs will be able to look back 3 years from the date the claim was paid
- RACs will not review claims paid prior to October 1, 2007

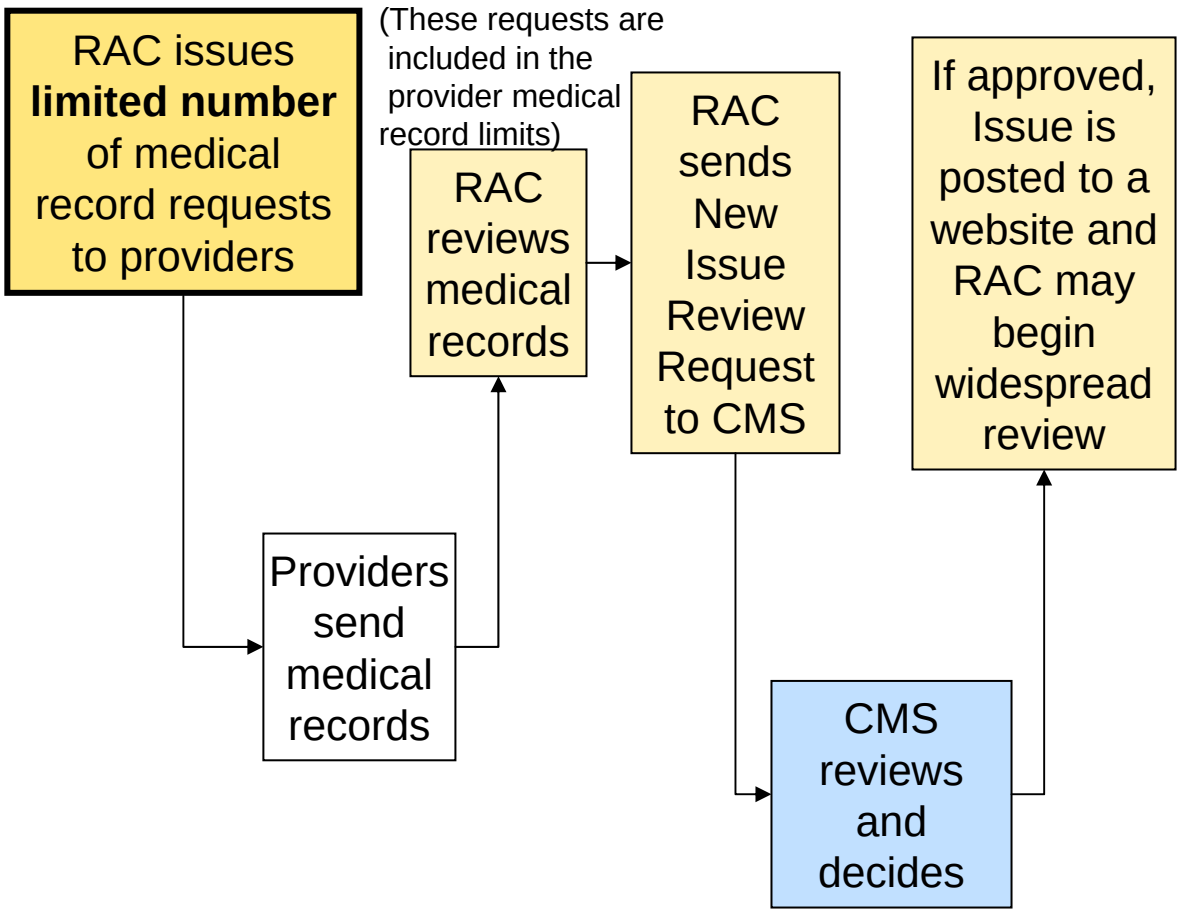
RAC Contacts at CMS

RAC	CMS Contact Person	Phone
A DCS	Ebony Brandon	410-786-1585
B CGI	Scott Wakefield	410-786-4301
C CONNOLLY consulting	Marie Casey	410-786-7861
D HealthDataInsights™	Marie Casey	410-786-7861

New Issue Review Process for **AUTOMATED**



New Issue Review Process for **COMPLEX**



NOTE:
In cases where CMS has not decided by Day 60, RAC will issue **limited number** of Review Results Letters without CMS approval and web posting.

Requesting Medical Records

- RACs will send letters requesting medical records like Carrier/FI/MAC & CERT
- RACs must pay for inpatient hospital records
- Failure to submit requested record in 45 days = denial
- CMS has established medical record limits, RACs must follow established medical record limits
- Providers are encouraged to have a point of contact
- Providers can submit medical records via:
  - Mailed paper copy or
  - Fax or
  - Mailed CD/DVD

CMS is exploring the development of a secure web interface for use by those providers who wish to upload imaged medical records to the RAC

Reviewing Claims

- RACs use same Medicare policies as FIs, Carriers and MACs: NCDs, LCDs & CMS manuals
- RACs are required to use nurses, therapists, certified coders & physician CMD

Period of Discussion

- Each RAC will offer a period of discussion to providers
  - For Automated: discussion period begins with demand letter
  - For Complex: discussion period begins with review results letter
- During the discussion period the provider will be able to provide additional information to the RAC to support their claim or to discuss the improper payment with the RAC
- The discussion period does not necessarily preclude recoupment

The Collection Process

- Same as for Carrier/FI/MAC identified overpayments (except demand letter comes from the RAC)
  - Carrier/FI/MAC issue Remittance Advice
    - Remark Code N432: “Adjustment Based on Recovery Audit”
  - RAC issues Demand Letter
  - Carrier/FI/MAC recoups by offset unless provider has submitted a check or provider has submitted a valid appeal

Summary: Review & Collection Process

Automated Review

1 New Automated Review Issue Posted to RAC's website

2 RAC makes a claim determination

Complex Review

6 New Complex Review Issue Posted to RAC's Website

7 RAC issues **Medical Record Request Letter** to provider

- Provider has 45 + 10 calendar days to respond
- Providers may request an extension
- Claim is denied if no response

8 Provider submits medical records

9 RAC clinician reviews medical records;

makes a claim determination

- RAC has 60 calendar days from receipt of medical record to send the Review Results Letter

10 RAC issues **Review Results Letter** to provider (does NOT include $$$ or appeal rights)

If no findings STOP

The Collection Process

3 Carrier/ FI/MAC issues **Remittance Advice (RA)** to provider

N432: "Adjustment based on a Recovery Audit"

4 **Day 1**

RAC issues **Demand Letter to Provider** (includes $$$ and appeal rights) INTEREST BEGINS TO ACCRUE AFTER 30 DAYS FROM DETERMINATION

5 **Day 41**

Carrier/FI/MAC **recoups by offset**

- Recoupment will NOT occur if:
  - ✓provider has paid in full; or
  - ✓provider filed an appeal BY day 30

Provider Choices After Receiving A Demand Letter

1a. Allow recoupment (OP + int) on Day 41 & do not appeal

1b. Allow recoupment (OP + int) on Day 41 & file appeal by Day 120

2a. Pay on/before check by Day 30 (interest is not assessed) & do not appeal

2b. Pay by check on/before Day 30 (interest is not assessed) & file an appeal by Day 120

3. Stop the recoupment by filing an appeal prior to Day 31

4a. Request or apply for an extended repayment plan (OP+ int) & do not appeal

4b. Request or apply for an extended repayment plan (OP+ int) & appeal by Day 120

Reminders

- Discussion Period is not a substitute for the Appeals Process
- New **Automated** Review Issues will always be posted to the web before demand letters are sent
- New **Complex** Review Issues will usually be posted to the web before medical record request letters are sent

Keys to RAC Program Success

1. Minimize Provider Burden
2. Ensure Accuracy
3. Maximize Transparency

Key #1:
Minimize Provider Burden

- Limit the RAC “look-back period” to 3 years
- Maximum look back date 10/1/07
- RACs will accept imaged medical records on CD/DVD
- Limit the number of medical record requests

Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
  - **10%** of avg mthly Medicare claims (max of 200) per 45 days
- **Other Part A Billers** (Outpatient Hospital, HH)
  - **1%** of average monthly Medicare services (max of 200) per 45 days
- **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 Billers** (DME, Lab)
  - **1%** of average monthly Medicare services per 45 days

Medical Record Limit Example

Outpatient Hospital

- 360,000 Medicare paid services in 2007
- Divided by 12 = avg 30,000 Medicare paid svcs/mth
- x 1% = 300
- **Limit = 200 records/45 days (hit the max)**

Key #2: Ensure Accuracy

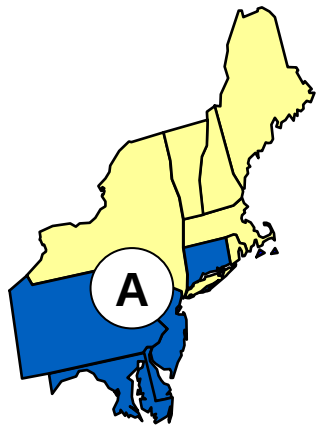
- Each RAC has:
  - A physician medical director
  - Certified coders
- CMS New issue review board (greater oversight)
- RAC Validation Contractor
  - Annual accuracy scores for each RAC
- If a RAC loses at any level of appeal, RAC must return contingency fee

Key #3:
Maximize Transparency

- New issues posted to web
- Vulnerabilities posted to web
- RAC claim status web interface (2010)
- Detailed review results letter following all complex reviews

Region A – Outreach Schedule

State	Date	Contact
MA	Nov 13th	MA Hospital Assoc
NH	Nov 3rd Nov 4th	NH Hospital Assoc
ME	Nov 12th	ME Hospital Assoc
NY	Nov 6th	NY Healthcare Assoc
	Nov 5th	Greater NY Assoc
RI	Nov 19th	RI Hospital Assoc
VT	Nov 20th	VT Hospital Assoc



DCS

What Can I do to Prepare:

FIRST, Know where previous improper payments have been found

- Look to see what improper payments were found by the RACs:
  - ✓ *Demonstration RAC findings:* *www.cms.hhs.gov/rac*
  - ✓ *Permanent RAC findings: will be listed on the RACs' webpages.*
- Look to see what improper payments have been found in OIG and CERT reports
  - ✓ OIG reports: *www.oig.hhs.gov/reports.html*
  - ✓ CERT reports: *www.cms.hhs.gov/cert*

What Can I do to Prepare:

SECOND, Know if you are submitting claims with improper payments

- Conduct an internal assessment to identify if you are in compliance with Medicare rules.
- Identify corrective actions that need to take place to be in compliance

What Can I do to Prepare:

THIRD, Get Ready to Respond to RAC Medical Record Requests Fully and Promptly

- Tell your RAC the precise address and contact person they should use when sending Medical Record Request letters
  - ✓ Fall 2008: call RAC
  - ✓ No later than 1/1/2010: use RACs' websites
- When necessary, check on the status of your medical record (did the RAC receive it?)
  - ✓ Fall 2008: call RAC
  - ✓ No later than 1/1/2010: use RACs' websites

Who will be in charge of responding to RAC medical record request?

What address will we use?

Who will be in charge of tracking our RAC medical record requests?

What Can I Do To Prepare: FOURTH, Appeal When Necessary

- The appeal process for RAC denials *is the same* as the appeal process for Carrier/FI/MAC denials

- Don't confuse the "RAC Discussion Period" with the Appeals process.

  If you disagree with the RAC determination…

  - ✓ Don't stop with sending a discussion letter
  - ✓ File an appeal before the 120 day after the demand letter.

Who will be in charge of deciding whether to appeal a RAC denial?

How will we keep track of what we want to appeal, what we have appealed, what our overturn rate is, etc.?

What Can I do to prepare: FIFTH, Learn From Your Mistakes

- Keep track of denied claims
- Look for patterns
- Determine what corrective actions you need to take to avoid improper payments

Who will be in charge of tracking our RAC denials, looking for patterns?

How will we avoid making similar mistakes in the future?

DCS

DCS, a Performant Company:
Recovery Audit Contractor (RAC) Presentation
November 2008

DCS (Diversified Collection Services)

- Subsidiary of Performant Financial Corporation
- Over 32 years experience providing service to large government agencies and private companies
- Services and products include:
  - Technology platform, portfolio management, improving operational efficiency, revenue optimization and risk management services
- Strategic relationships that are built on improving revenue, process improvements and value-partnerships in a highly regulated, security sensitive environment

DCS' Experience

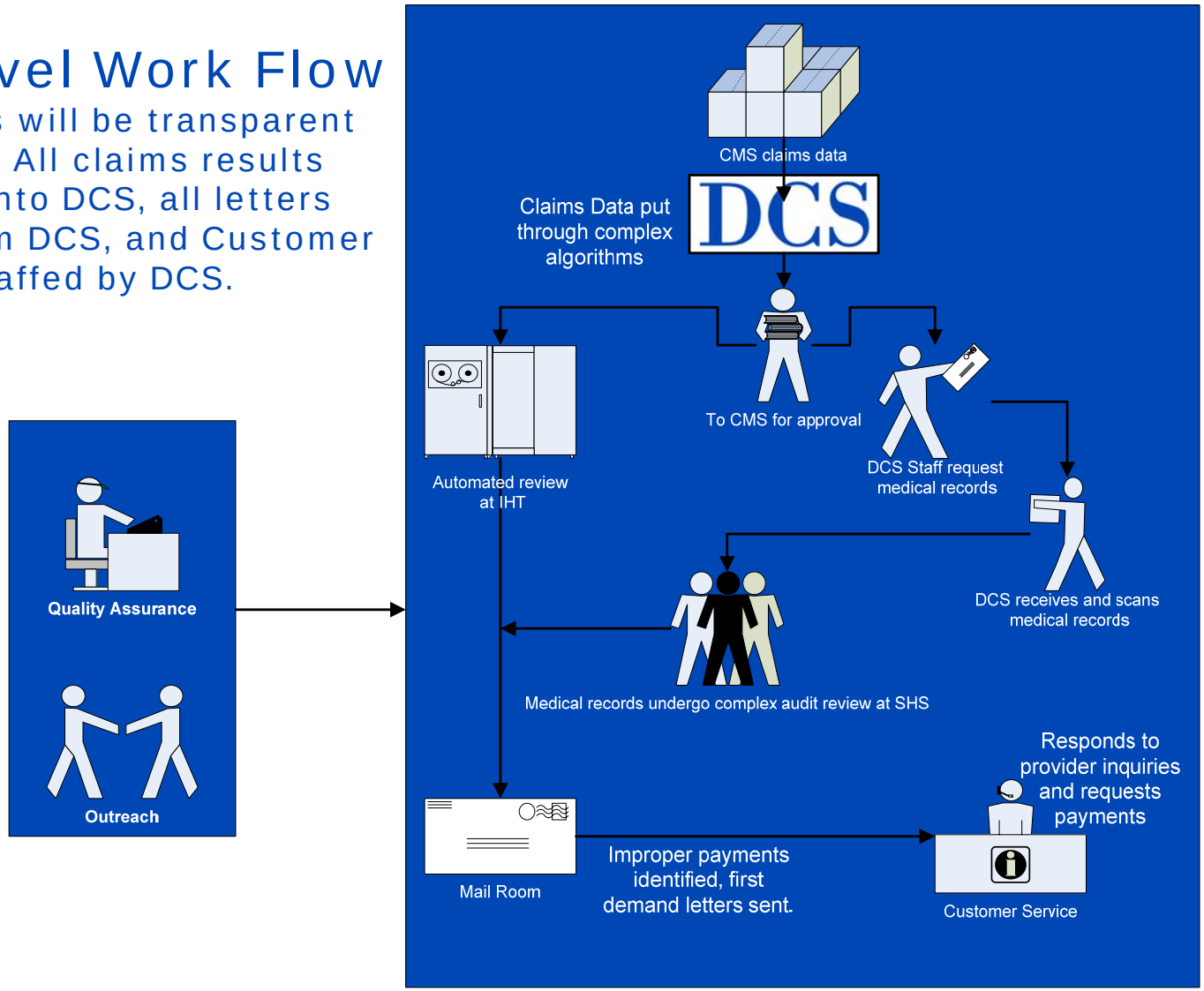
- CMS MSP RAC Demonstration (California)
- CMS Recovery of Medicare Beneficiary Prescription Drug Benefit Premium
- U.S. Departments of Treasury and Education
- State taxing authorities
- Federally chartered state student loan guarantee agencies
- Large financial institutions

DCS' Roles and Locations

- Livermore, CA:
  - Outreach
  - Information Technologies
  - Contract Management
  - Corporate Compliance
- San Angelo, TX:
  - Customer Service and Recovery
  - Training and QA
  - Identifying claim vulnerabilities
  - Requesting and tracking of medical records
  - Mail room functions including accepting and scanning incoming mail and mailing letters and demands
  - RNs and Certified Coders
  - Customer service hours – 8:00am - 4:30pm (EST)

High Level Work Flow

This process will be transparent to providers. All claims results flows back into DCS, all letters are sent from DCS, and Customer service is staffed by DCS.



DCS' Subcontractors

- Auditing is divided into two main categories:
  - Automated Reviews also known as "data mining"
  - Complex Audit Reviews also known as "medical record chart reviews"
- iHealth Technologies (iHT) will assist with Part B automated reviews
- Strategic Health Solutions (SHS) will assist with Part A and B complex reviews

iHT's Role as Subcontractor

- Maintain and update library of CMS rules, regulations, guidelines or coding policies
- Review CMS policies and edits with DCS and administer them for CMS Part B claims on a post payment basis
- Maintain Contracted Medical Director as well as alternate Medical Directors
- Has 150+ employees and 45 contractual resources

SHS' Role as a Subcontractor

- Provide a team of nurses and/or Certified Coders experienced in performing complex audits/reviews of improper payments
- Assist DCS in identifying claim vulnerabilities
- Utilize DCS' system to review medical records and make:
  - Coding review determinations (RNs or Certified Coders)
  - Medical Necessity review determinations (done by MDs)
- Document using DCS' system the findings and reasons to support the improper payment decision
- Respond to customer service inquiries regarding provider questions on claim determinations

Contracted Medical Director (CMD)

- Full time with extensive knowledge of the Medicare program
- Provides clinical oversight for the Medical Operations department and an expert panel of 35 physicians
- Guide and oversee RN reviews
- Provide the clinical expertise and judgment to understand LCDs, NCDs and other Medicare policy

Customer Service

- Dedicated core competencies – technology, people, process – committed to delivering best-in-class results to CMS
- Stable workforce and best people – tenured management team, client services, production workforce
- Goal is to exceed CMS expectations by applying innovation and best practices
- Trained and knowledgeable staff to interact with providers

Inquiries/Question Process

- Inquiries or questions contact 1-866-201-0580 or e-mail DCSRAC@performantcorp.com
- Inquiries or questions will be answered in a timely manner
  - Customer service will collect details and investigate to determine the appropriate action
- Contact the DCS Outreach Department via e-mail at dharrison@performantcorp.com

Questions & Answers

CMS Contact Information

CMS Website and E-mail

www.cms.hhs.gov/RAC

RAC@cms.hhs.gov

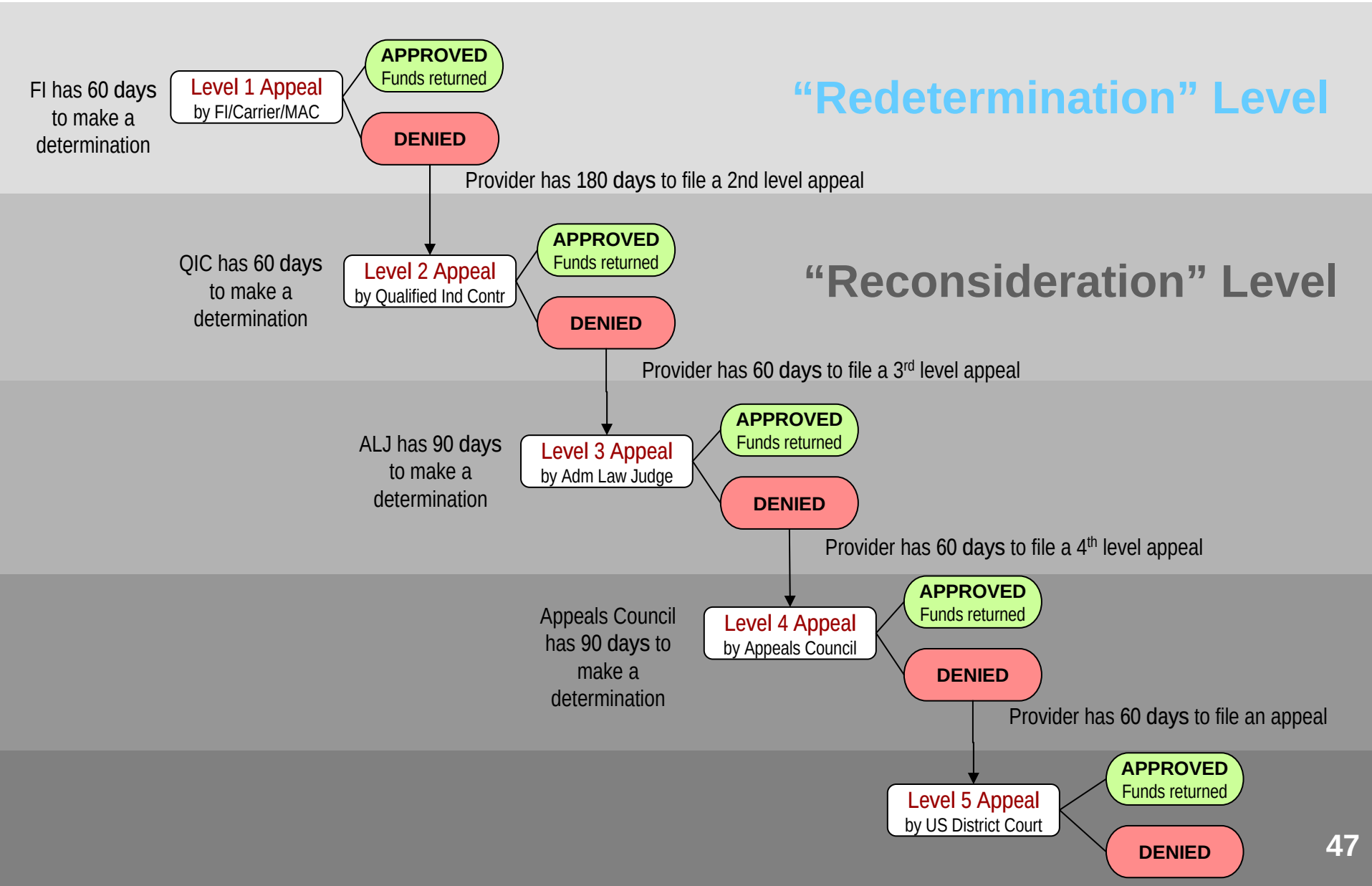
"It is critical that we ensure every dollar is spent wisely so that the program is affordable for taxpayers and future generations of beneficiaries."

--Kerry Weems, Acting CMS Administrator

Appendices

Medicare Appeals Process

Provider has 120 days from the demand letter to File a 1st level appeal!



Roles of Various Medicare Improper Payment Review Entities

	Types of Claims	How selected	Volume of Claims	Purpose of Review
QIO	Inpatient Hospitals	All claims where hospital submits an adjusted claim for a higher-weighted DRG Expedited Coverage Reviews requested by beneficiaries	Very small	To prevent improper payments through DRG upcoding To resolve discharge disputes between beneficiary and hospital
CERT	All	Randomly	Small	To measure improper payments
MAC	All	Targeted	Depends on number of claims with improper payments for this provider	To prevent future improper payments
RAC	All	Targeted	Depends on number of claims with improper payments for this provider/item/service	To detect and correct past improper payments
PSC	All	Targeted	Depends on number of potentially fraudulent claims submitted by provider	To identify potential fraud
OIG	All	Targeted	Depends on number of fraudulent claims submitted by provider	To identify fraud

APPENDIX D

D. Website Resources

- **Table of RAC Website Resources**

APPENDIX D – RAC Website Resources

Subject/Entity	Description (if applicable)	Website
American Hospital Association (AHA)		http://www.aha.org/aha/issues/RAC/index.html
Cahaba	The Medicare Administrative Contractor (MAC)	http://www.cahabagba.com
CMS – Center for Medicare and Medicaid		http://www.cms.hhs.gov/RAC
CMS Document	"How Can Recovery Audit Contractors Help Me?"	http://www.medicare.gov/Publications/Pubs/pdf/11349
CMS-588 Form (See also Electronic Data Interchange (EDI) Trading Partner Agreement below.)	CMS requires that each provider currently enrolled for Electronic Funds Transfer (EFT) complete a new CMS-588 for the new MAC. This form is a legal agreement between a provider and the MAC that allows funds to be deposited into the provider's bank account. It is critical for the MAC to receive these forms before any payments are issued.	http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf
CMS Medicare Learning Network	Destination for educational information for Medicare fee-for-service providers. Located in CMS, the Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives. The Network plays a key role in furthering the Agency's culture of responsiveness.	http://www.cms.hhs.gov/MLNGenInfo/
CMS National Coverage Determination Manual		http://www.cms.hhs.govcoverage/ or http://www.cms.hhs.gov/Manuals/IOM/list.asp

CMS Press Release		http://www.cms.hhs.gov/apps/media/press/factsheet.asp
CMS RAC Email Updates		http://www.cms.hhs.gov/aboutWebsite/20_EmailUpdates.asp#TopOfPage
Comprehensive Error Rate Testing (CERT)	This program measures the error rate for claims submitted to applicable federal contractors.	http://www.CERTprovider.org
Connolly & Associates	RAC Contractor, Region C	http://www.connollyhealthcare.com/
Electronic Data Interchange (EDI) Trading Partner Agreement (See also CMS-588 Form above.)	A new MAC may also request a provider execute a new EDI Trading Partner Agreement.	http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf
Healthcare Financial Management Association (HFMA)	This page guides users to HFMA resources on the *Recovery Audit Contractor* (RAC) program, which was developed as a demonstration project to identify improper.	http://www.hfma.org/library/reimbursement/medicare/RAC.htm
Local Coverage Determinations (Georgia)		http://www.georgiamedicare.com/MedicalReview.cfm
Medicare Update as of February 6, 2009		http://www.medicareupdate.typepad.com/medicare_update/2009/02/racbidprotests.html
Medicare Update as of January 22, 2009		http://www.medicareupdate.typepad.com/medicare_update/2009/01/racproteststatus.html
MM5979: "Assignment of Providers to Medicare Administrative Contractors"		http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5979.pdf
National Guideline Clearinghouse (NCG)	Public resource that includes evidence based clinical practice guidelines that could be useful in supporting medical	http://www.guideline.gov

	necessity of services.	
Office of Inspector General (OIG) for U.S. Department of Health & Human Services	This cite includes access to the OIG's Advisory Opinions; Alerts, Bulletins & Other Guidances; Compliance Guidance; Corporate Integrity Agreements; Enforcement Actions; Exclusion Programs; Open Letters; Reporting Fraud: Safe Harbor Regulations; Self-Disclosure Information, State False Claims Act Reviews.	http://www.oig.hhs.gov
Office of Inspector General – Work Plans	The OlG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department's major entities: the Centers for Medicare & Medicaid Services; the public health agencies; and the Administrations for Children, Families, and Aging. This cite includes 2009 work plan which should give providers a background as to what the OIG is looking at this year.	http://www.oig.hhs.gov/publications/workplan.asp
PEPPER REPORTS- Program for Evaluating Payment Patterns Electronic Report		http://www.hpmpresources.org/PEPPER/AboutPepper/
PRG-Schultz Announces Subcontracts with Three Medicare Recovery Audit Contractors		http://news.moneycentral.msn.com/ticker/article.aspx?Feed=BW&Date=20090209&ID=9589311&Symbol=PRGX
RAC Audits by 3M Health Information Systems US		http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Help_Me_With/Overview/RAC-Audits

TMF Health Quality Institute, CMS HPMP Quality Improvement Organization Support Center (QIOSC)	Developed to provide information, tools and data to hospitals and healthcare providers related to payment error prevention.	http://www.hpmpresources.org
Viant Health Payment Systems	RAC Subcontractor will be assisting Connolly & Associations in Region C.	http://www.viant.com