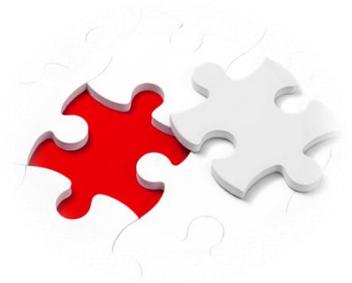


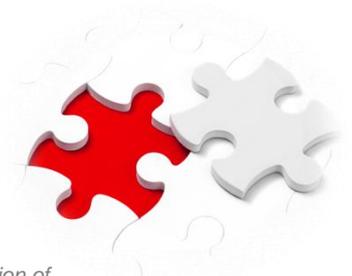
# Peer to Peer: RAC and MAC experience

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# RAC Discussion: Blast from the Past

- High volume 250-400 claims every 56-60 days
- Denial rates 30-45% (HDI)
- Process: all denied claims sent back with letter requesting re-review (start discussion)
  - 10-25% denied claims overturned (PHASE 1)
- Review all upheld claims
  - Rebill; written appeal; P2P (PHASE 2)



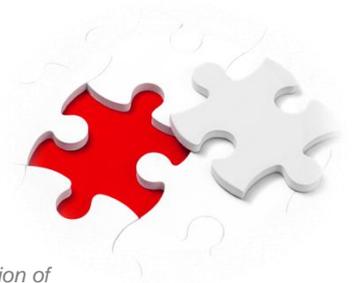
# RAC Discussion: Blast from the Past

- Advantages we had
  - Same HDI consultant MD for 2+ years of discussions
  - Careful screening of cases we brought forward
  - Tracking results: “you may recall that you overturned a similar case 4 months ago...”
- Support anyone can use
  - LITERATURE support whenever possible: PESI score, ABCD2 scores, PSI etc.
  - Local standard of care: large geographic referral base
  - Specific patient information: make the patient REAL



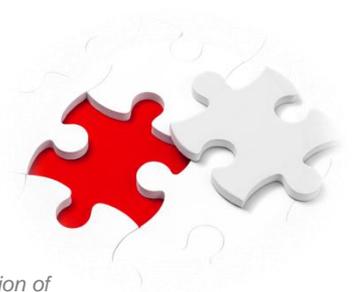
# MAC “Discussion:” Facet/MBB LCD

- Denials for “radiculopathy”
- Denials for “no physical examination included.”
- Redetermination denials for same rationale when new records included.
  
- Email and telephone conversations with nurse reviewers to request re-looks instead of sending appeals to QIC



# MAC “Discussion:” Facet/MBB LCD

- Education
  - definition of “radiculopathy”
  - difference between subjective description from patient and objective findings on PE.
  - Interpretation of “conservative measures”
- Challenges:
  - pre-pay reviewers and redetermination reviewers do not communicate.
  - Part A and Part B reviewers are not the same



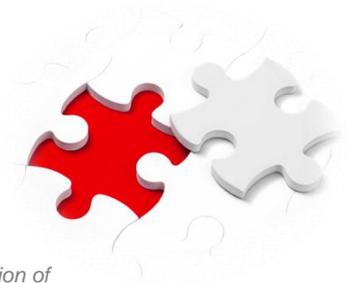
# MAC “Discussion:” E&M

- Education:
  - Requested due to denials
  - CMS IOM: *When medical review (MR) notification and feedback letters are issued, the MAC MR staff shall ensure that Provider Outreach and Education (POE) staff has access to copies of the letters in case a provider requests further education or POE determines that future education is needed. While program savings are realized through denials of payment for inappropriate provider billing, the optimal result occurs when compliance is achieved and providers no longer incorrectly code or bill for non-covered services*



# MAC “Discussion:” E&M

- Challenges
  - Medical necessity and NOPP are open to interpretation
  - Noridian will not release their auditing tool
  - LOW DOLLAR amounts per claim
- Outcomes
  - Webinar and face to face education
  - Single contact person at Part B
  - Escalate to Regional Office?



# TAKE HOME POINTS

- Find key personnel and stick with them: “Who can be the point person for my facility?”
- Ask for and PROVIDE education: Don’t assume they know more than you do!
- Know when to push and when to let it go: Feelings matter. You catch more flies with honey...
- Assume best intentions: Everyone has a job to do



# THANK YOU!

