Current RAC Concerns From Around the Country Across All Health Care Sectors

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Audit . Tax . Consulting . Financial Advisory .

Agenda

- Demonstration Project Results and Concerns
- CMS Actions to Address Concerns
- Current Provider Concerns
- Questions/ Share Concerns

Demonstration Project Results

CMS announces the 3-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina, and Arizona collected over $900 million in overpayments and returned nearly $38 million in underpayments to providers.

Source: CMS press release 10/6/08. For more information visit: http://www.cms.hhs.gov/RAC

Demonstration Project Results

- 900 Million in overpayments; $38 Million in underpayments
- 96% of the claims were overpayments and only 4% were underpayments
- Only 14% of RAC denial decisions were appealed with 4.6% of them resulting in reversal of the RAC decision
- CMS has published reports on overpayments, appeals and appeal success rates however final demonstration project results still in progress of being updated as appeals in progress are brought to a close.

Source: www.**cms**.hhs.gov/**RAC**/Downloads/AppealUpdatethrough83108of**RAC**Eval**Report**.pdf

Demonstration program issues and concerns roll forward

- **Updated Appeals of RAC Determinations**

– "From the inception of the RAC demonstration through August 31, 2008,providers chose to appeal 22.5 percent (118,051) of the RAC determinations. Overall, the data indicate that of all the RAC overpayments determinations (525,133), only 7.6 percent (40,115) were overturned on appeal".

Table JU7: Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, Claim RACs Only

APPEAL ACTIVITY & OUTCOME SUMMARY	
Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	118,051
Number of claims with appeal decisions in provider's favor	40,115
Percentage of appealed claims with a decision in provider's favor	34.0%
Percentage of claims overturned on appeal	7.6%

Source: www.**cms**.hhs.gov/**RAC**/Downloads/AppealUpdatethrough83108of**RAC**Eval**Report**.pdf

Demonstration Program Concerns

- Providers agree that overpayments occurred in the reported areas however RAC “mistakes” and/or overzealous denial decisions have caused concern and created a level of mistrust of RAC results

  - Inpatient rehabilitation facilities experienced high volume of denials for medical necessity which were later overturned (27%) upon appeal review. Inappropriate application of criteria by RACs cited.
  - Acute care hospital “short stay” admissions were denied based upon solely on the inability to meet Interqual™ inpatient admission criteria even QIOs and contractors may have given providers other policy guidance to apply.
  - Hospital providers in some states reported recoupment action taken prior to or simultaneously with provider notification of overpayment
    - Thirty-two South Carolina hospitals filed suit in July, 2008 alleging $30 million in recoupments were inappropriately initiated.

Sources: King and Spaulding Publications, July 21, 2008 www.kslaw.com ; http://www.cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf

Demonstration Program Concerns

■Provider mistrust of RAC results and concerns (cont'd)

- Providers in some states during the demonstration program reported that RAC reviewers did not possess the clinical/ coding credentials and skills to perform audits resulting in inaccurate denial decisions.
- Allegations that CMS allowed RACs to utilize different interpretations of medical necessity guidelines.
- Some providers reported that RACs did not have physician medical directors actively engaged in review/ oversight of inpatient admission/ high cost denials as is considered common Utilization Review/ Utilization Management practice in the industry.

Source: *CMS* http://www.cms.hhs.gov/RAC

CMS Addresses Concerns

During the demonstration period CMS was required to address all concerns raised by a RAC or any other interested party while identifying successes and opportunities for improvement before the program is expanded nationally

Demonstration Contract	Permanent Program
1) *No maximum* look back period.	1) The *look back period* has been changed from 4 years to *3 years* in the permanent program. (No claims prior to Oct 2007).
2) Not allowed to review claims during the current fiscal year.	2) Allowed to review claims during the current fiscal year.
3) Certified coders were *optional*.	3) Certified coders are *mandatory*.
4) *Optional* medical record limit set by the individual RAC.	*4)* *Mandatory limits* for medical records are set by CMS.

Source: *2007 RAC Status Document, CMS* http://www.cms.hhs.gov/RAC

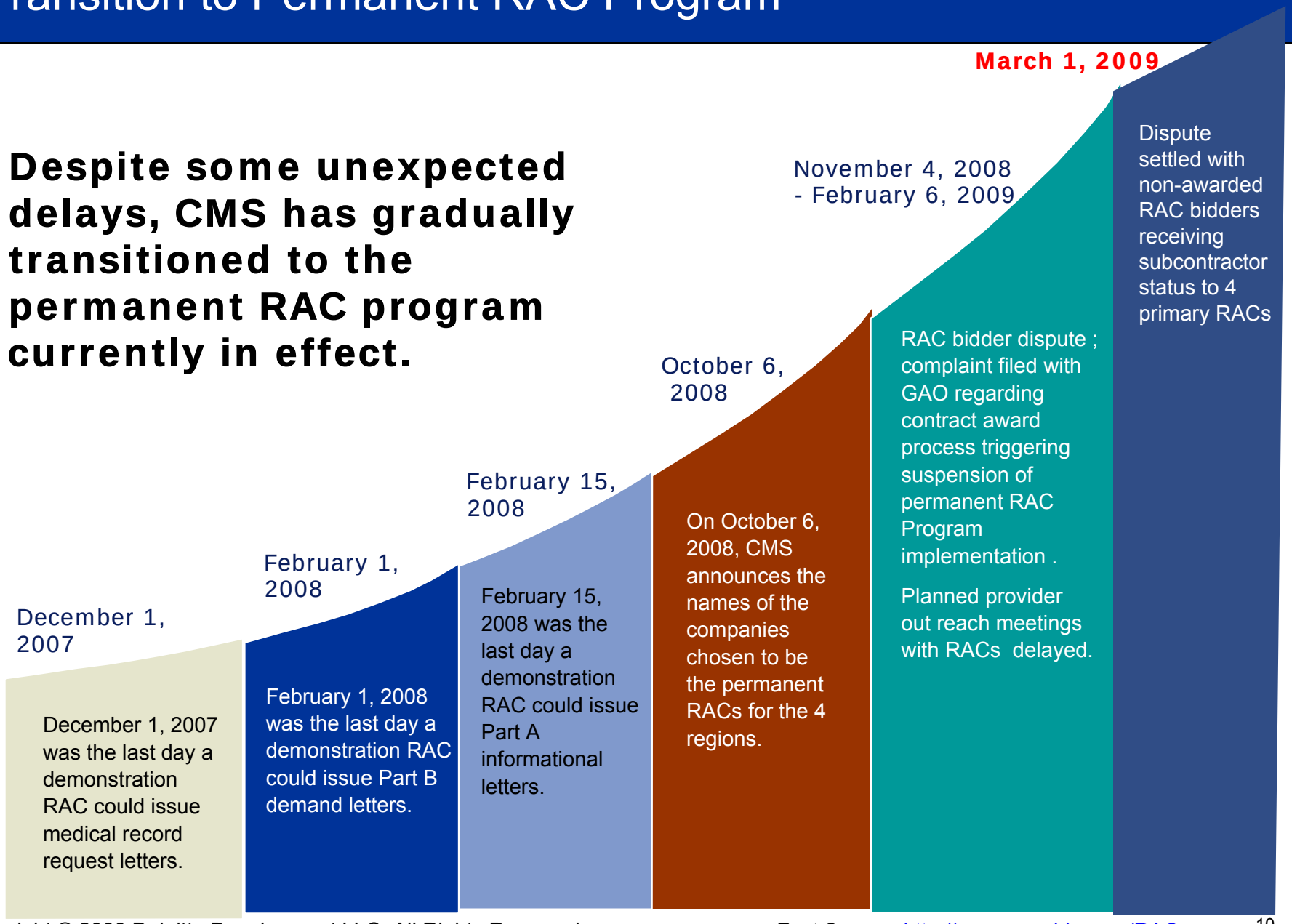
CMS Addresses Concerns

Demonstration Contract	Permanent Program
4) Contractor Medical Directors *optional*	4) Contracted Medical Directors *mandatory*, single dedicated FTE versus multiple part-time FTEs
5) RACs *retained their contingency fees* even if the case denial was overturned at the Administrative Law Judge (ALJ) level or above.	5) RACs will be *paid only on denials that are upheld* on every level of appeal.
6) Tracking and notification of the status of reviews, denials and appeals not consistently meeting requirements; providers unable to access data to track the status or receive timely response to questions	6) RACs will be required to maintain *Web portal for providers by 2010*

Source: *2007 RAC Status Document, CMS* http://www.cms.hhs.gov/RAC

Transition to Permanent RAC Program

Despite some unexpected delays, CMS has gradually transitioned to the permanent RAC program currently in effect.



Fact Source: http://www.cms.hhs.gov/RAC

Current Provider Concerns

- RAC use of extrapolation and how prior “failed” Medicare contractor interventions will be cited as rationale by RACs to employ extrapolation techniques
  - “CMS envisions a RAC contractor using extrapolation in cases where there was evidence of a sustained or high level of payment error or where documentation education intervention by the carrier/FI/MAC/QIO had failed to correct the payment error”
  - Many hospital providers believe that the continued inpatient medical necessity issues identified and denied by the RACs may meet extrapolation criteria
    - Quality Improvement Organizations (QIO) have attempted to correct medical necessity issues (e.g., inpatient short stays) with intense education and outreach as part of the Hospital payment Monitoring Program (HPMP) with Program for Evaluating Payment Patterns Electronic Reports (PEPPERs).
  - Other types of issues impacting non-hospital providers could be evidenced as failing to improve despite ongoing contractor intervention

Current Provider Concerns

- In potential cases involving statistical sampling and extrapolation across potentially large universes of claims, will hospitals have enough time to adequately review RAC determination and extrapolation methods and take advantageous of rebuttal opportunity before needing to make the decision to appeal?
- When inpatient admissions are denied for medical necessity, providers may be able to obtain Ambulatory Payment Classification (APC) depending upon timely filing guidelines.
  - Cases that do not meet inpatient admission criteria often will meet outpatient observation care admission criteria.
  - Providers asking why necessary to re-file an outpatient APC claim if the RAC has determined a lesser level of care was appropriate? Why not treated as other types of claims with payment reduction adjustments ?
  - Depending upon the type of services rendered, the gap between the inpatient and outpatient payments amount could vary significantly but the provider's cash flow may be impacted by recoupment while going through the re-filing process and awaiting APC payment.

Current Provider Concerns

- Underpayments in the Medicare RAC program are 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.
  - Missed charges (service lines or payment groups that a provider failed to include on a claim) are **NOT** considered underpayments under the RAC program
- Providers questioning the underpayment definition and lack of ability to re-bill missed charges.

Source Underpayment Definition: 2J-1RAC SOW 11-5-07 VS2

Current Provider Concerns

- RACs are required to identify underpayments however not financially incentivized to do so.
- Providers are concerned RACs will not as aggressively identify underpayments and/or may not notify the provider timely to expect the related payment adjustment
  - Upon identification the RAC will communicate the underpayment finding to the appropriate affiliated contractor (AC) shall share any documentation supporting the underpayment determination with the AC.
  - After receipt the AC will validate the Medicare underpayment, adjust the claim and pay the provider.
  - RAC will issue a written notice to the provider, an Underpayment Notification Letter which will include the claim(s) and beneficiary detail.

Current Provider Concerns

- Each RAC is required to have only one physician Medical Director.
  - Providers expect to experience continued medical necessity denials (high RAC error rates) associated with nurse only application of UR screening criteria without second level physician review.
  - Section 1879 of the Social Security Act ultimately holds hospitals to local and national standards of care which require physician review.
  - Some providers believe CMS should have required second level review on all inpatient medical necessity denials and by not mandating it, this will increase providers burden to appeal and defend. Providers questioning why RAC physician review requirements (%s) are not mandated based upon the RACs volume of denied cases.
  - Given volume of cases RACs reviewed during demonstration, unlikely a single physician could perform a second level of review on majority cases identified for denial by nurse reviewers if rebuttals and appeals increase.

Current Provider Concerns

RAC Validation Contractor (RVC)

- CMS announced it hired Provider Resources, Inc. of Erie, PA as the RVC
- RVC intended to fill role of Independent third party review entity to work with CMS to provide additional oversight and ensure the RACs are making accurate claim determinations in the permanent program.
- The RVC will have two tasks
  - Perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments.
  - Approve new issues the RACs want to pursue for improper payments
- Providers concerned that RVC may not adequately assess all RAC proposed issues prior to providing RACs the approval to proceed with targeting a new range of issues.
- Providers asking when CMS and the RACs will publish new target areas under consideration or approved? Will 2009 OIG Work plan issues be rubber stamped by RVC?
- Medicare payments for sleep studies increased from $62 million in 2001 to $215 million in 2005.Medical necessity coverage for specific conditions/ symptoms (e.g. sleep apnea, narcolepsy, impotence, or parasomnia)

Source: *CMS* http://www.cms.hhs.gov/RAC and OIG 2009 Work Plan

Current Provider Concerns

What will the new RAC target areas be for each provider type and setting?

- Hospitals and physician practices continue to monitor and educate internally on improper payment issues highlighted in RAC demonstration project as “lessons learned” including but not limited to:

- Excisional debridement (incorrectly coded)
  - Cardiac defibrillator implant in wrong setting (medically unnecessary inpatient admissions)
  - Colonoscopies (medical necessity)
  - Treatment for heart failure and shock in wrong setting (medically unnecessary inpatient admissions)
  - Infusion and transfusion services (medical necessity)
  - Drug medical necessity and unit billing issues, e.g. Neulasta, Lupron
  - Multiple, duplicative procedures performed same day or medically unlikely combinations of procedures
  - Inpatient Admission medical necessity, principal diagnosis accuracy and discharge disposition assignments

Current Provider Concerns

Even if demonstration targeted DRGs (below) do not change initially, hospital providers no longer have QIO PEPPER reports to assist in tracking DRG utilization patterns.

DRG	Description
217	Wound debridement and skin graft procedures
263	Skin graft and/or debridement for skin ulcer or cellulites
243	Medical back problems
416	Septicemia
397	Coagulation disorders
138	Cardiac Arrhythmia with CC
143	Chest Pain
124	Cardiac Catheterization with Complex Cardiac Diagnosis

DRG	Description
477	Non-extensive OR Procedure Unrelated to Principal Diagnosis
468	Extensive OR procedure Unrelated to Principal Diagnosis
85	Pleural Effusion with CC
475	Mechanical Ventilation for Respiratory Disorders
440	Wound Debridement for Injuries
188	Other Digestive System Diagnoses with CC
462	Rehabilitation for inpatient rehabilitation facilities

Current Provider Concerns

- Skilled Nursing Facilities monitoring and educating staff on:
  - Admissions denied for lack of prior 3-day hospital stay
  - Documentation/ Minimum Data Set (MDS) reporting issues driving resource utilization group (RUG) denials and/or reduction in RUG reimbursement via lower level RUG assignment by RACs
    - Physical therapy and occupational therapy services (medically unnecessary)
    - OIG work plan for 2009 indicates psychotherapy services are a review focus provided to skilled nursing facility (SNF) residents during non-covered Part A stays; will the RACs target psychotherapy also?
      - Nursing homes are required by regulation to provide care and services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Current Provider Concerns

- Durable Medical Equipment Suppliers are continuing to monitor and educate internally on documentation gaps
  - Lack of supporting medical necessity documentation medical necessity
  - Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs) as well as orders/ other documentation substantiation by treating physician
  - Items provided during a hospital inpatient stay or SNF stay
  - Underlying diagnosis code accuracy for medical necessity; updating diagnosis codes over time.

Current Provider Concerns

- Many physician practices experiencing overpayment demands report not aggressively appealing RAC denials during the demonstration period

- Lack of resources, degree of practice disruption, lack of understanding of RACs utilization/ potential misinterpretation of Carrier policies

  - Urology specialties- "least costly alternative" policy enforcement; Carrier approval of larger payments than written guidelines dictated.
  - Other specialties administering high cost drugs (Hematology/ Oncology, Rheumatology) concerned they will be targeted without cause

- Physicians reported low dollar claims also targeted during the demonstration; practices weighing cost/ benefit of appealing however future CMS/ RAC extrapolation policy is unclear and represents another consideration.

  - "Physicians are concerned that more doctors will be targets for review if E&M codes and claims for less than $25 are fair game"

Sources: American Medical News, July 11, 2008. http://www.ama-assn.org/amednews/2008/07/07/gvsa0707.
Informal interviews with physician clients

Current Provider Concerns

Physician practices preparing but concerned about costs and lack of other resources (cont'd)

- Professional societies advocating focus on monitoring and educating in areas of RAC demonstration program;
  - Infusion and drug medical necessity and unit issues
  - Vestibular Function testing
  - Medicare global surgical billing and payment rules for hospital outpatient claims (including cases involving evaluation and management visits).
- Larger groups investing in understanding evaluation and management trends to peers, e.g. use of CMS and other available E&M peer data.
  - Understand potential cause for RACs to target them
  - Sharing data with specialty peers in their geography

Current Provider Concerns

- Top risk areas voiced by home care providers as concerns for near term RAC audits related to:
  - Diagnosis coding
    - Single versus multiple necessary diagnoses documented
    - Updating diagnosis codes for longer term patients with
  - Medical necessity
    - Multiple same day skilled nursing visits, e.g. diabetics unable to self-inject insulin
    - Home bound status
    - Extended hospice LOS and validity of terminal illness certification
    - Certification and re-certification dating/ timing documentation insufficiency

Source: Informal interviews with home care/ hospice providers and representatives of NA

Current Provider Concerns

- While some home care providers are expressing concern and preparing, others are not yet concerned; lack of demonstration project focus on this subset of providers may have impacted range of concern levels.

- Home care industry provider survey
  - Nearly half of those surveyed say diagnosis coding is one of their clinicians' biggest challenges.
  - More than 90 percent of homecare providers are not concerned about Recovery Audit Contractors (RACs).
  - More than 75 percent of homecare providers responded they have NOT seen the revised OASIS (OASIS-C) assessment and documentation requirements for 2010; and thus are not prepared to implement changes currently.

Source: Beacon Health, HCPRo Survey, January 2009

Current Provider Concerns

- Common thread of home care/ hospice concern are clinical documentation gaps, e.g. documenting key dates and details of changes in ongoing condition beyond the admission to home/ hospice care.
- Complex review types likely given medical necessity, certification frequency requirements.
  - Example: extended hospice LOS and validity of terminal illness certification
    - ✓ Two physicians must sign the initial certification of terminal illness; only one physician is required to certify the patient's prognosis for subsequent certifications
    - ✓ Increased volume of patients living past the expected six month period inviting review to confirm status
      - May receive certification up to 2 weeks prior to a certification period, but may be no later than 2 days after the period begins.
      - Physician Signature requirements; May not use a physician stamp must be handwritten.
      - Documentation in the clinical record should reflect the prognosis of the disease, e.g. radiological studies, physician progress notes, physician office notes, Karnofsky Performance Scale, Functional Assessment Staging, Palliative Performance Score.

Current Provider Concerns

- At CMS discretion, the RAC may receive referrals or "tips" on potential overpayments from CMS, ACs, and OIG or law enforcement.
- Other potential risk areas exist where RACs may receive referrals to focus on as services/ claims begin to fall under new regulations
  - Meeting new OASIS-C assessment and documentation requirements
  - Meeting new Conditions of Participation requirements; home care example
    - Ensuring that the most appropriate level of service is provided.
      - ✓ Interpretive Guidelines for §484.18 of the Conditions Participation. "Medicare orders may authorize a specific range in the frequency of visits for each service (for example, 2-4 visits per week) to ensure that the most appropriate level of service is provided to the patient." CMS Publication 100-2, Chapter 7, §30.2.2, reiterates the use of ranges to ensure the most appropriate service to the patient.
      - ✓ Orders may include ranges of frequency of visits; acceptable if to benefit the patient's need that may vary slightly week to week.
  - Are ranges being manipulated for provider convenience or patient medical necessity? Are physicians notified of missed visits as required? Is the quality of care being impacted?

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