National Medicare RAC Summit
March 5, 2009

Provider Lessons From Demonstration States

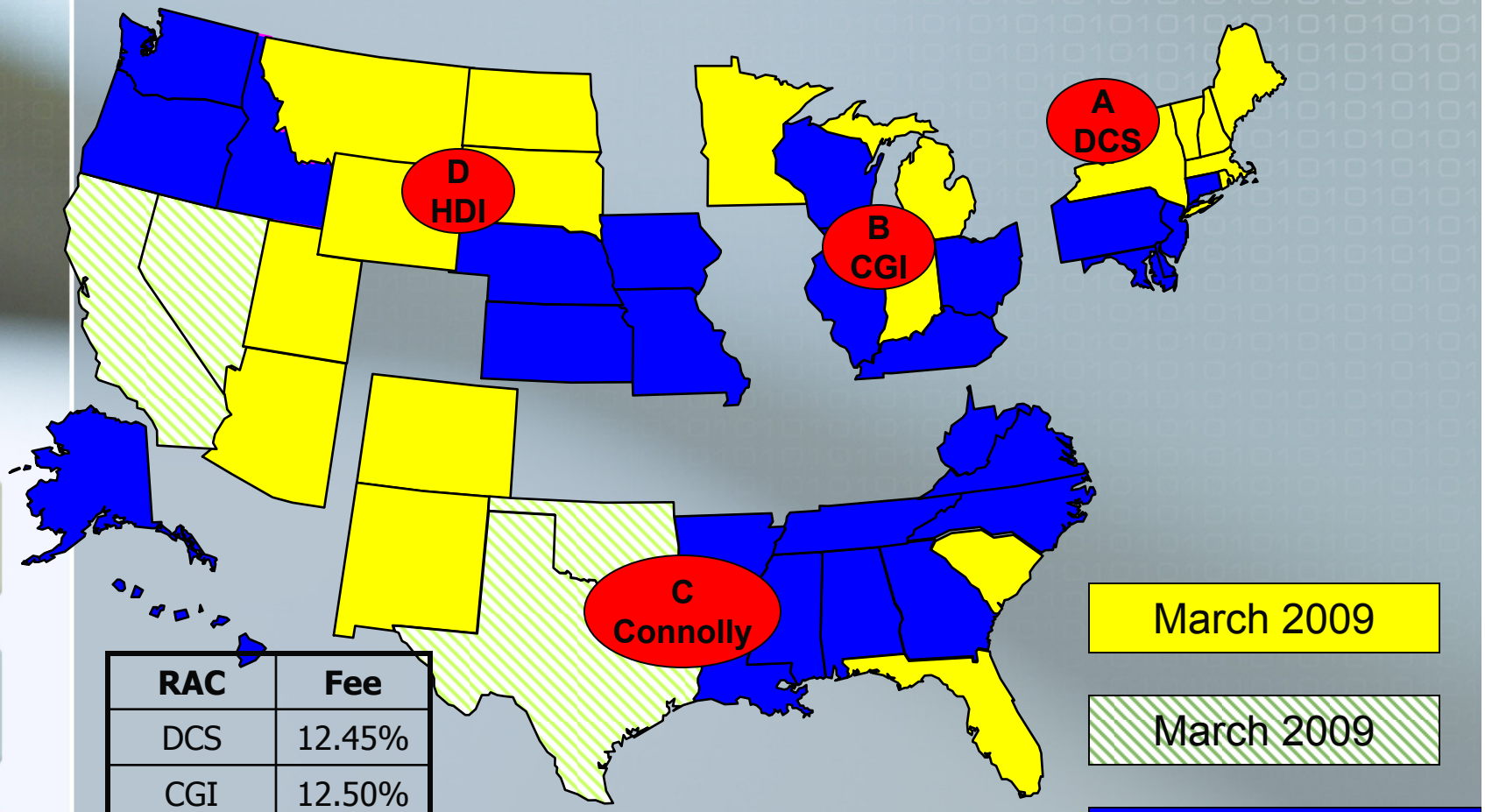
Lynn H. Grieves
Chief Compliance Officer
MemorialCare Medical Centers
lgrieves@memorialcare.org

MemorialCare®
Excellence in Health Care

MemorialCare Health System

- Non-profit 5 hospital health system
- 1,500 Licensed beds
- 10,000 Employees
- 3,300 Medical Staff Members
- 200,000 ER visits
- 85,000 Discharges
- $150M Community Benefit
- $1.5 B Net Revenue
- 25% Medicare Payor Mix

RAC Expansion Schedule



RAC	Fee
DCS	12.45%
CGI	12.50%
Connolly	9.00%
HDI	9.49%

Medical Record Request Limits

- **I/P Hospital, IRF, SNF, Hospice, Psych**
  - **10%** of avg. monthly claims (max of 200) per 45 days
- **Other Part A Billers (O/P Hospital, HH)**
  - **1%** of avg. 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

RAC Review Types

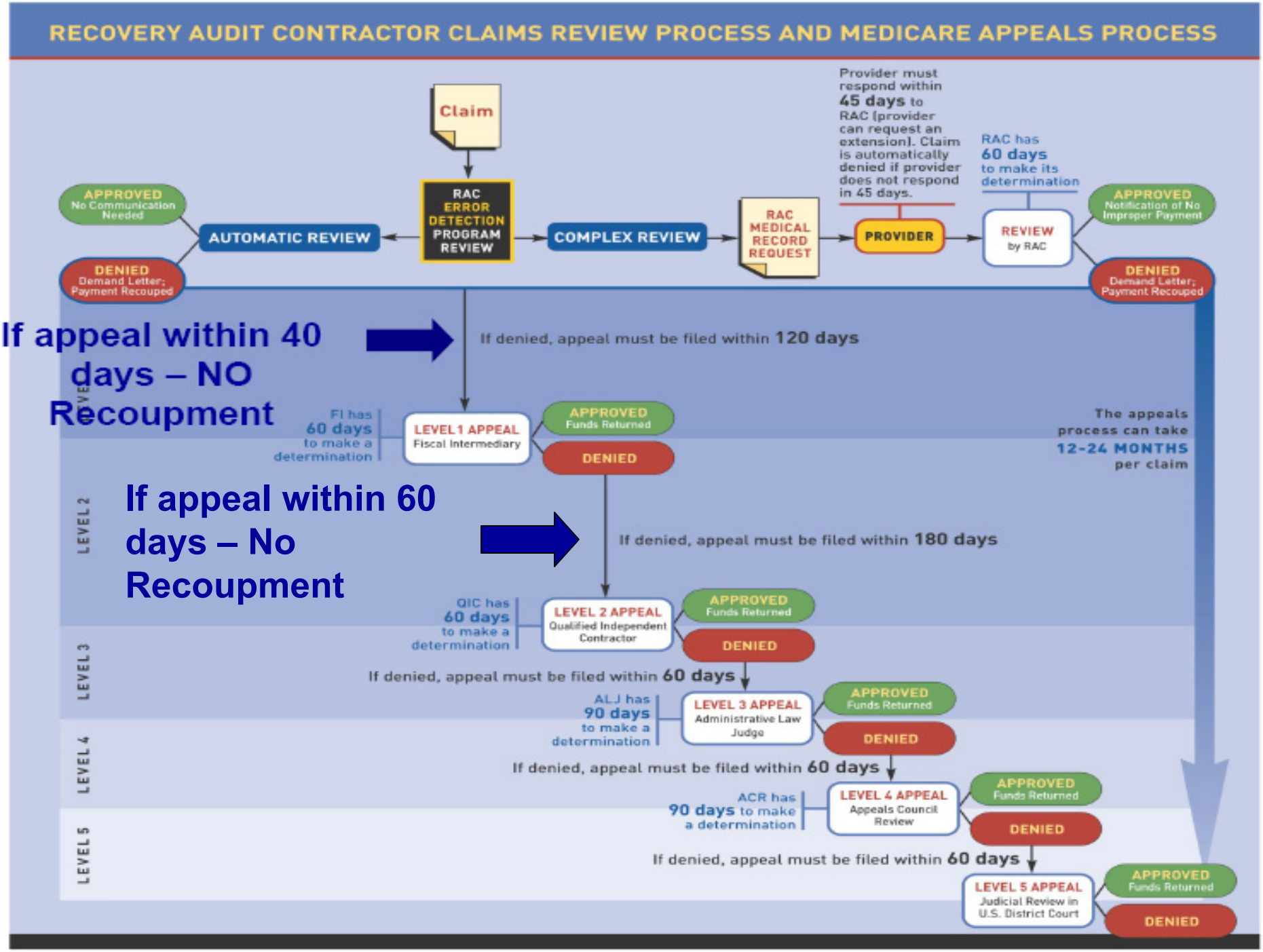
- Automated Reviews
  - Medically Unlikely
  - Duplicate Billing
  - No opportunity to rebut RAC finding
- Complex Medical Record Review
  - Coding reviews
  - Medical Necessity reviews

RAC Status January 2009

MemorialCare Medical Centers	Total
# of Chart Reviews Completed by RAC	2,103
# of Accounts Modified Down	1,119
# of Accounts Modified Upward	29
% of Accounts Modified Down	53%
Total # of Claims Modified by RAC * Medical Necessity * Coding	1,148 **894** 254
# of Accounts with Dollars Retracted	1,063
Net Dollars Retracted	$9,743,897

RAC Status January 2009

MemorialCare Medical Centers	Total
# of Claims Appealed at 1st Level (F.I.)	808
1st Level Appeals Completed by F.I.	721
Upheld	643
Overturned	78
# of Claims Appealed at 2nd Level (QIC)	580
2nd Level Appeals Completed by QIC	533
Upheld	423
Overturned	110
# of Claims Appealed at 3rd Level (ALJ)	292
3rd Level Appeals Completed by ALJ	224
Upheld	1
Overturned	223
# of Claims Appealed at 4th Level (MAC)	117
4th Level Appeals Completed by MAC	36
Appeals Reprimanded back to ALJ	36
# of Overturned Claim Appeals Repaid	**271**
$ of Overturned Claim Appeals Repaid	**$2,632,647**


RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS
Claim
RAC ERROR DETECTION PROGRAM REVIEW
APPROVED No Communication Needed
AUTOMATIC REVIEW
DENIED Demand Letter; Payment Recouped
COMPLEX REVIEW
RAC MEDICAL RECORD REQUEST
Provider must respond within 45 days to RAC (provider can request an extension). Claim is automatically denied if provider does not respond in 45 days.
PROVIDER
RAC has 60 days to make its determination
REVIEW by RAC
APPROVED Notification of No Improper Payment
DENIED Demand Letter; Payment Recouped
If appeal within 40 days – NO Recoupment
If denied, appeal must be filed within 120 days
LEVEL 1
FI has 60 days to make a determination
LEVEL 1 APPEAL Fiscal Intermediary
APPROVED Funds Returned
DENIED
The appeals process can take 12-24 MONTHS per claim
If appeal within 60 days – No Recoupment
If denied, appeal must be filed within 180 days
LEVEL 2
QIC has 60 days to make a determination
LEVEL 2 APPEAL Qualified Independent Contractor
APPROVED Funds Returned
DENIED
If denied, appeal must be filed within 60 days
LEVEL 3
ALJ has 90 days to make a determination
LEVEL 3 APPEAL Administrative Law Judge
APPROVED Funds Returned
DENIED
If denied, appeal must be filed within 60 days
LEVEL 4
ACR has 90 days to make a determination
LEVEL 4 APPEAL Appeals Council Review
APPROVED Funds Returned
DENIED
If denied, appeal must be filed within 60 days
LEVEL 5
LEVEL 5 APPEAL Judicial Review in U.S. District Court
APPROVED Funds Returned
DENIED

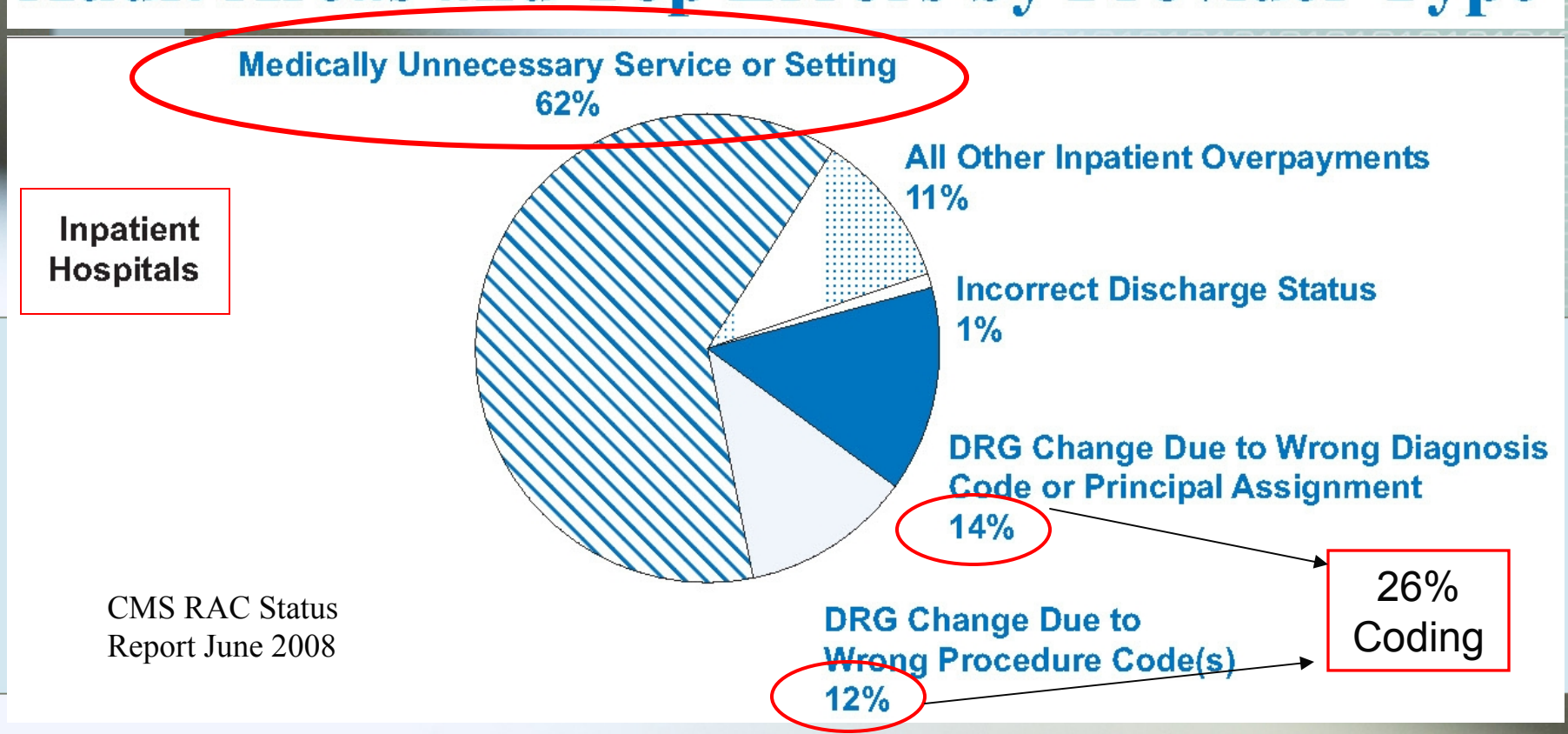
MemorialCare Appeal Experience

- 78% of RAC denials = Medical Necessity
- 22% of RAC denials = Coding Issues

- 808 of 1,063 claims with payment retractions have been appealed (76%).
- 271 appeals repaid thus far $2,632,647
- 1st level of appeal - 11% overturn rate
- 2nd level of appeal - 21% overturn rate
- 3rd level of appeal – 99.6% overturn rate

RAC Areas of Focus

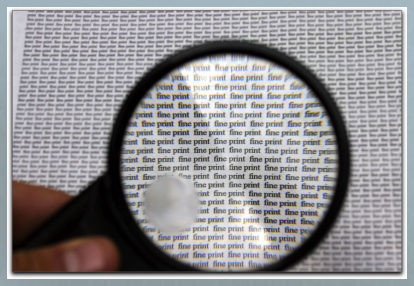
Appendix F
Audit Areas and Top Errors by Provider Type



CMS RAC Status Report June 2008

RAC Focus at MemorialCare

- 117 different DRG's reviewed
  - Medical Necessity
    - Acute Rehab Joint Replacements
    - Short Stays (especially cardiac implant surgeries)
  - Coding
    - Wound Debridement
    - Septicemia
    - DRG's with Complex Diagnosis



RAC Denial Letters

- RAC Auditor justification listed on denial letters
  - Lab results, excerpts from physician and nursing notes
  - General Statements:
    - "failed to meet Interqual criteria"
    - "Not a CMS inpatient only procedure"
    - "Pt discharged in stable condition"

RAC Denial Letters

- 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.

Operational Challenges

- Not prepared for the volume of requests and associated activities
- Slow to develop centralized internal tracking & workflow process
- Hampered by evolving nature of RAC pilot project
- Internal and external communication problems
- Lack of denials & appeals management expertise

MemorialCare Response

- RAC Work Team
- Shared Network Drive & Documentation Management RAC Tracking Tool
- Use of Outside Consultants
  - Attorneys, Physician Advisors, Coding
- Education – Board/Staff/MD's
- Hospital Association Involvement

Recommended RAC Preparation Activities

- Assess your Risks
- Design your RAC Work Flow
- Develop/Acquire Electronic RAC Tracking Capability
- Evaluate your Human Capital

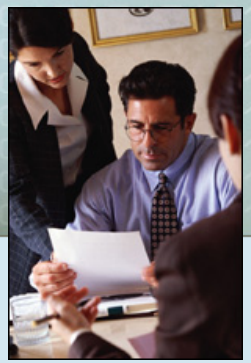
"By failing to prepare you are preparing to fail"

Benjamin Franklin

Risk Assessment

Considerations

- ✓Data Mining
- ✓Documentation Review
- ✓Evaluation of Key Processes
  - ✓Assignment of Admission Status
  - ✓Physician Query Process



Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Risk Assessment

Medical Necessity

- ✓Does your facility have/use an Observation level of care in your ED?
- ✓Is there Case Management in your ED and Cardiac Cath Lab?
- ✓Do you have a second level physician review as part of Case Management?
- ✓Do you have outdated forms in either the ED or Cardiac Cath Lab?

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Risk Assessment

Coding

✓Does your facility currently perform retrospective coding reviews?

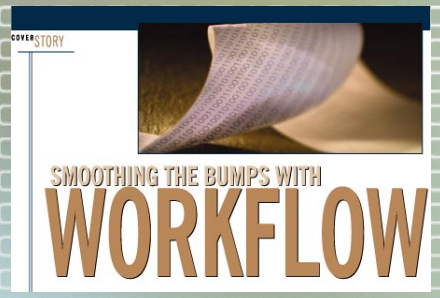
✓Does your facility perform regular APC Audits?

✓Does your facility include HIM assessments as part of your Compliance plan? What do you report to your Compliance Committee?

These reports not only identify potential problems, but can also provide evidence to CMS and others that you have a formal audit & monitoring policy.

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Work Flow



Considerations

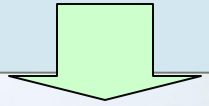
- ✓ Identification of internal and/or external resources to be involved in your RAC response/review/appeal process
- ✓ Determine the level of centralization desired
- ✓ Determine the level of automation to be implemented
- ✓ Clearly document responsibilities
- ✓ Understand key triggers and important timelines

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Work Flow

Key Departments Involved In Workflow

- ✓Revenue Cycle
- ✓Case Management
- ✓Health Information Management
- ✓Patient Financial Services
- ✓Information Services
- ✓Outside Contractors (Attorneys, Appeals, IS)



Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Work Flow

Planning Today Prevents Problems Tomorrow

- ✓ Strategic/Operational Decision Points
  - ✓ Electronic vs. Paper
    - ✓ Document Management Capabilities
    - ✓ Submit Records on CD vs. Paper
  - ✓ Appeals Strategy
    - ✓ Aggressive vs. Selective
    - ✓ Retain Funds vs. Utilize Full Appeal Timelines

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Tracking and Reporting

Considerations

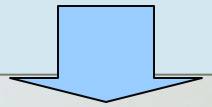
- ✓ Size of Organization & Medicare Payor Mix
- ✓ Degree of Centralization in Work Flow
- ✓ Level of Desired Automation
- ✓ Minimum Acceptable Reporting Capabilities
- ✓ Short Term or Long Term Horizon

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Tracking and Reporting

Tracking Tool Comparison Table

	Excel	Access	Proprietary
Cost			
Reporting			
Automation			
Customization			
Imaging			



Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Tracking and Reporting

Tips

- ✓ Develop and run activity reports at regular intervals
  - ✓ Medical Records Due in 15 days
  - ✓ Appeals by Level Due in 15 days
  - ✓ Denials trended by MS-DRG, Physician, Primary Diagnosis, LOS, reason for denial, etc.
- ✓ Financial impact reporting including dollars at risk and dollars retracted
- ✓ Appeals activity – success by level of appeal

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Human Capital

Important position control:

- ✓ **RAC Coordinator**
  - ✓May be full time or part time based on volume. Calculate based on 10% of total IP discharges and 1% of OP services.
- ✓ **HIM Staffing**
  - ✓Make sure you have adequate staffing for Medical Record requests or use copy service. There is a provision for copy fees under the RAC Program
  - ✓Have internal or external resources re-review RAC coding denials
- ✓**Case Management**
  - ✓For Medical Necessity Appeals, budget two hours per appeal. This may decrease as the process becomes refined

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Human Capital

RAC Process
Sample Associated Costs

	Monthly Total	Yearly Total	Cost	Comment
Chart Requests	100	1200	$36,000	$30/Chart mailing cost
Rebuttal	50	600		
Medical Necessity	25	300	$4,500	$15 mailing costs
Coding	25	300	$4,500	$15 mailing costs
			$9,000	
1st Level	50	600		
Medical Necessity	25	300	$27,000	$75/Medical Necessity + $15 mailing costs
Coding	25	300	$27,000	$75/Coding Review + $15 mailing costs
			$54,000	
2nd Level	45	540		
Medical Necessity	23	270	$4,050	$15 mailing costs
Coding	23	270	$4,050	$15 mailing costs
			$8,100	
3rd Level	35			
Medical Necessity	18	211	$76,869	$350/Outside Fees + $15 mailing costs
Coding	18	211	$76,869	$350/Outside Fees + $15 mailing costs
MD Expert Witness	18	211	$21,060	$100/Case
			$174,798	
RAC Coordinator			$60,000	
Chart Copy Fee Repayment			($28,800)	
Total Expense			$313,098	

Risk Assessment	Work Flow	Tracking and Reporting	Human Capital

Resources

- **CMS RAC Status Reports, Statement of Work, FAQs, Expansion Schedule, Fact Sheets, Press Releases, etc.**
  - www.cms.hhs.gov/RAC/
- **CMS Appeals Process**
  - www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf
- **American Hospital Association RAC Resources**
  - www.aha.org/aha/issues/RAC/aharesources.html
- **Transmittal 1457 – Redeterminations of Overpayments**
  - www.cms.hhs.gov/Transmittals/Downloads/R1457CP.pdf
- **Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments**
  - www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf
- **Transmittal 1671 – New & Material Evidence (Good Cause)**
  - http://www.cms.hhs.gov/transmittals/downloads/R1671CP.pdf
- **OIG Audit of Medicare ALJ Hearings 7/08**
  - www.oig.hhs.gov/oei/reports/oei-02-06-00110.pdf
- **OIG Audit of QIC Medicare Appeals Processing 7/08**
  - http://www.oig.hhs.gov/oei/reports/oei-06-06-00500.pdf

Appendix

Medical Necessity – High Risk RAC 1 Day non-surgical admission denials normally attributed to the ED

MS-DRG	DRG Description
313	Chest pain
291	Heart failure & shock w MCC
292	Heart failure & shock w CC
293	Heart failure & shock w/o CC/MCC
392	Esophagitis, gastroent & misc digest disorders w/o MCC
391	Esophagitis, gastroent & misc digest disorders w MCC
192	Chronic obstructive pulmonary disease w/o CC/MCC
190	Chronic obstructive pulmonary disease w MCC
191	Chronic obstructive pulmonary disease w CC
069	Transient ischemia

Appendix

Medical Necessity - High Risk RAC 1 Day surgical denials normally attributed to invasive cardiology

MS-DRG	DRG Description
244	Permanent cardiac pacemaker implant w/o CC/MCC
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC
243	Permanent cardiac pacemaker implant w CC
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
259	Cardiac pacemaker device replacement w/o MCC
242	Permanent cardiac pacemaker implant w MCC
245	AICD lead & generator procedures
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC
226	Cardiac defibrillator implant w/o cardiac cath w MCC
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents
261	Cardiac pacemaker revision except device replacement w CC
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC
262	Cardiac pacemaker revision except device replacement w/o CC/MCC

Appendix

Common Coding Related RAC Revisions

DRG	Description
389	G.I. obstruction w CC
375	Digestive malignancy w CC
194	Simple pneumonia & pleurisy w CC
309	Cardiac arrhythmia & conduction disorders w CC
253	Other vascular procedures w CC
187	Pleural effusion w CC
674	Other kidney & urinary tract procedures w CC
092	Other disorders of nervous system w CC
071	Nonspecific cerebrovascular disorders w CC
543	Pathological fractures & musculoskelet & conn tiss malig w CC
908	Other O.R. procedures for injuries w CC
312	Syncope & collapse
330	Major small & large bowel procedures w CC
372	Major gastrointestinal disorders & peritoneal infections w CC

Appendix

MR Request

08/21/2007

Subject: Request for Medical Records

[redacted]

Patient name:

HIC Number:
Date of Birth:
Medical Record Number:
Patient Control #:
Date(s) of Service:
Claim Reference #:
Case ID:
Medicare # :

[redacted]

Please do not write in this area

[redacted]

Please Return Original Request with Medical Records

The Recovery Audit Contractor is requesting medical record copies specified below in order to perform a DRG Validation on behalf of the RAC Demonstration. In accordance with 42 U.S.C. 1320C-5 (a) (3) and 1833 of the Social Security Act, as a Medicare provider, you must provide documentation and medical records upon request to support claims for Medicare services.

Records should be submitted to the following address within **45** days from the date of this letter. Your response is required even if you are unable to locate the records requested. Providing medical records of Medicare patients to this CMS contactor request is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Copy fees associated to this request should be at the CMS rate of 12 cents per page. Please mail medical record copies to:

Recovery Audit Contractor
535 E. Diehl Rd.
Naperville, IL 60563
Attention DRG Validation Department

Please submit the following components of the medical record ***along with this letter:***

X	FACE SHEET	X	LABORATORY REPORTS
X	DISCHARGE SUMMARY	X	RADIOLOGY REPORTS
X	HISTORY & PHYSICAL	X	OPERATIVE REPORTS (IF APPLICABLE)
X	EMERGENCY ROOM REPORT	X	PATHOLOGY REPORTS (IF APPLICABLE)
X	CONSULTATIONS	X	ICD 9 CM CODES SUBMITTED
X	PHYSICIAN ORDERS	X	PHYSICIAN QUERY
X	PHYSICIAN PROGRESS NOTES	X	ANESTHESIA RECORD

Questions regarding this request should be directed to the Provider Relations Department at 866-638-1766.

Sincerely,

William Davis
Medicare Project Director
PRG-Schultz International, Inc.
REF NUM: C4GU00880196

RAC Denial

002/003

[redacted]

Attn: Case Management Department - Contact: [redacted]

[redacted]

Notification Date:
From:
HIC Number:
Date of Birth:
Medical Record Number:
Patient Name:
Patient Control #:
Date(s) of Service
Reference Number:
CPS ID:
Medicare Number:

[redacted]

Dear Medicare Provider,

This is to let you know that you have received a Medicare payment in error which has resulted in an overpayment to you for services dated 02/25/2003 to 02/26/2003. The following explains how this happened.

How this overpayment was determined:

This claim was chosen for complex review and was denied after reviewing the medical records.Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states no payment may be made under part A or part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The following explains the basis of our determination:

PROVIDER DRG ASSIGNMENT: 115 - CARDIAC PACEMAKER DEVICE REPLACEMENT

Principal Diagnosis Code	V5331
Secondary Diagnosis Code	42611
Principal Procedure Code	3787
Secondary Procedure Code	----

RAC - Audit Determination Rationale

Claim failed to meet Interqual Severity of Illness (SI) criteria for acute care Inpatient admission. Patient presented for pacemaker generator change which is not an Inpatient procedure. Claim was billed and paid as an Inpatient instead of outpatient Patient admitted 02/25/2003 at 10:40 and dc'd 02/26/2003 at 09:25.Surgery paperwork is all " Outpatient/Short Stay"

REF NUM: C4GU00453649

Appendix

2nd Level Denial

CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Appeal Number: [redacted]

Medicare Reconsideration Decision

July 24, 2008

[redacted]

RE:
Beneficiary: [redacted]
HIC #: *****[redacted]
Appellant: [redacted]

Dear [redacted]

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for the services shown under the Appeal Details section.

The appeal decision is UNFAVORABLE. Our decision is that Medicare will make no additional payment. More information on the decision is provided on the next pages. You are not required to take any action. If you disagree with the decision, you may appeal to an Administrative Law Judge (ALJ). You must file your appeal, in writing, within 60 days of receipt of this letter. The amount still in dispute is estimated to be equal to or over $120. A copy of our decision has been sent to the parties shown below. First Coast Service Options was contracted by Medicare to review your appeal. For more information on how to appeal, see the page titled "Important Information About Your Appeal Rights."

Sincerely,

Eugene J. Winter, MD

Eugene J. Winter, MD
Medical Director

CC: [redacted]
National Government Services, Wisconsin

Contact Information

If you have questions, write or call:

First Coast Service Options
QIC Part A-West
P.O. Box 45029
Jacksonville, FL
32232-5029

Telephone:
904-791-6385

Who we are:
We are a Qualified Independent Contractor (QIC). Medicare has contracted with us to review your file and make an independent decision.

Rev: 03/01/08

ALJ Decision

ALJ No: [redacted]

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Western Field Office
Irvine, California

Appeal of: [redacted] Center	ALJ Appeal No: [redacted]
Beneficiary: [redacted]	**Medicare Part A**
HICN: [redacted]	Before: [redacted] **U.S. Administrative Law Judge**

DECISION

After careful consideration of the evidence and arguments presented in the record, a **FULLY FAVORABLE** decision is entered for [redacted] (Appellant).

Procedural History

The Appellant provided inpatient hospital services to the Beneficiary, [redacted], from November 18 to 19, 2003.

Medicare made an initial determination and the Appellant received payment from Medicare on December 9, 2003. (*See* Ex. 2, pg. 1.)

The Centers for Medicare and Medicaid Services (CMS) commenced a post-payment review through its Recovery Audit Contractor (RAC), PRG Schultz, and requested medical records for the Beneficiary for the dates at issue on December 14, 2006. (*See* Ex. 3, pgs. 1-3.) The RAC notified the Appellant in a Notice of Overpayment Findings that the Appellant had received an overpayment based on a review of the medical records on March 13, 2007. (*See* Ex. 3, pg. 4.)

The RAC gave the Appellant the option to rebut the RAC's overpayment decision within 15 days, or to appeal the adverse determination to United Government Services (UGS), the Fiscal Intermediary (FI) for CMS. The Appellant submitted a rebuttal to the RAC. The RAC responded, finding the services provided did not satisfy Medicare criteria. UGS recouped Medicare payments from the Appellant through electronic adjustments on July 31, 2007. (*See* Ex. 2, pg. 2.)

Thank You!

Lynn H. Grieves
Chief Compliance Officer
MemorialCare Medical Centers
lgrieves@memorialcare.org

MemorialCare®
Excellence in Health Care