

# RAC Audits of Physician Practices – The Current Landscape



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# National Error Rate

3<sup>rd</sup> Q 2010- 12.4%, 10.5% 2011

- Commitment to Reduce the Error
- President Obama recently announced the government's commitment to reduce the error rate by 50% (using a baseline of 12.4%) by 2012 (Was 3.8% \$10.3B in 2008)
  - – 9.5% for November 2010 Report
  - – 8.5% for November 2011 Report
  - – 6.2% for November 2012 Report
- Thru MAC, CERT, ZPIC, RAC, MIC, OIG, HEAT auditing...
- Funding PPACA by eliminating fraud, waste and abuse...

# CMS Claims Review Entities

## Roles of Various Medicare Improper Payment Reviews

Timothy Hill, CFO , Dir of Office on Financial Mgt

9-9-08 presentation

Entity	Type of claims	How selected	Volume of claims	Purpose of review
QIO	Inpt hospital	All claims where hospital submits an adj claim for a higher DRG. Expedited coverage review requested by bene	Very small	To prevent improper payment thru <b>upcoding</b> . To resolve <b>disputes</b> between bene and hospital
CERT	All	Randomly	Small	To <b>measure</b> improper payments
MAC	All	Targeted	Depends on # of claims with improper payments	To <b>prevent</b> future improper payments
RAC	All	Targeted	Depends on the # of claims with improper payments	To <b>detect and correct</b> <b>past</b> improper payments
PSCZPIC	All	Targeted	Depends on the # of potential fraud claims	To identify <b>potential fraud</b>
OIG	All	Targeted	Depends on the # of potential fraud claims	To identify <b>Fraud</b>



# Goal of the Audit Culture

- To ensure billed services are reflected in the documentation in the record
- To ensure billed services are in the medically correct setting for the pt's condition
- To ensure billed service reflect the 'rules' regarding billing for the specific service
- To ensure documentation can support all billed services according to the payer rules.
- **Physician Order matches what was done matches what was documented matches what was billed.**



# CMS Quarterly Newsletter, 3Q 2011

Region	Overpaymts (\$ in millions)	Underpaymt	Total 3 <sup>rd</sup> Q Corrections (Based on actual collections)	FY to Date Corrections Data thru June 30, 2011)
Region A DCS	\$40.4	\$5.0	\$45.4	\$98.2
Region B CGI	\$33.9	\$9.8	\$43.7	\$118.5
Region C Connolly	\$46.9	\$7.4	\$54.3	\$133.3
Region D HDI	\$112.2	\$33.7	\$145.9	\$242.5
<b>TOTALS</b>	<b>\$233.4</b>	<b>\$55.9</b>	<b>\$289.3</b>	<b>\$592.5</b>



# Top Issues per Region, CMS, 3Q 2011

- Region A: Renal and Urinary Tract Disorders (Not medically appropriate for inpt status)
- Region B: Extensive Operating room procedures unrelated to principal dx (DRG validation – primary and 2<sup>nd</sup> dx errors)
- Region C: Durable Medical Equipment/Prosthetics/DMEPOS (Automated review – no separate payment when inpt.)
- Region D: Minor surgery and other treatment billed as an inpt (Not medically appropriate for an inpt status.)



# First report to Congress –FY 2010

- “Implementation of Recovery Auditing at the CMS. FY 2010 Report to Congress” as required by 6411 of Affordability Act.
- Accuracy rate by the RACs: Low to high: DCS/98.6 –HDI/ 99.2%
- \$75 M in overpayments. 82% of all activity
- \$16 M in underpayments. 18% of all activity
- Reasons:
  - Not coded correctly
  - Not meeting Medicare’s guideline for an inpt
  - Supporting documentation does not match the order.



# Physician Practice Specific Issues of Focus

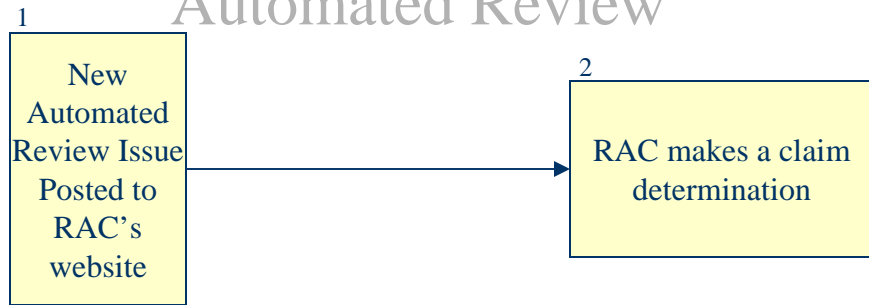


# Two types of RAC Audits

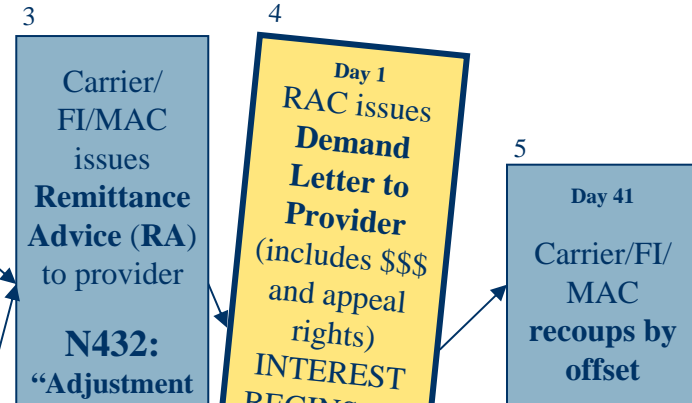
- Automated: No medical record is required to make a denial/recoupment decision. (Medically unbelievable services, units)
- Complex: Medically correct setting, E&M leveling, medically necessary services that require a medical record to make the denial/recoupment decision.

# Summary: Review & Collection Process

## Automated Review

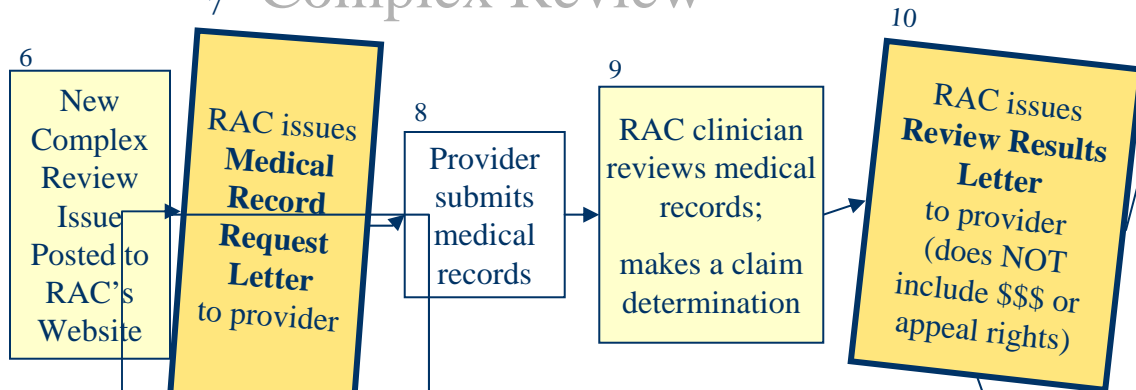


## The Collection Process



From Cmdr Casey, RN, CMS

## Complex Review



- Provider has 45 + 10 calendar days to respond
- Providers may request an extension
- Claim is denied if no response

- RAC has 60 calendar days from receipt of medical record to send the Review Results Letter

If no findings  
STOP

- Recoupment will NOT occur if:
  - ✓ provider has paid in full; or
  - ✓ provider filed an appeal BY day 30



# Physician Focus Areas

- Place of Service – office vs outpt hospital (SE1104 Med Learn)
- Separate E&M leveling within the surgical/CPT bundle period
- New vs Established
- Level of service conflicts with the hospital – doc /inpt; hospital/OBS
- Office E&M leveling is not a focus of the RAC audits ...yet



# Physician/Non PP Additional Documentation Limits

- As of 2-14-11, modified changes
- Limits based on physician or non PP's billing Tax ID # as well as the first three positions of the ZIP code where that physician/non PP is physically located.
- EX: Group ABC has TIN 12345 and two physical locations in ZIP code 4567 and 4568. This group qualifies as a single entry for additional documentation requests/ADR.
- Ex: Group XYZ has TIN 12345 and two physical locations in ZIP 4556 and 5566. This group would qualify as two unique entities for ADR



# More on Physician ADR

- ADR limits will be based on the # of individual rendering physician/non-PP reported under each TIN/ZIP combination in the previous calendar year. Reserves the right to exceed the cap indicated.

Group/Office Size	Maximum # of requests per /each 45 days
50 or more	50 records
25-49	40 records
6-24	25 records
Less than 5	10 records



# Additional CMS/MedLearn Training

- SE1024/July No documentation or insufficient documentation submitted
- SE1027/Sept Medical necessity vulnerabilities for inpt hospitals
- SE1028/Sept DRG coding vulnerabilities for inpt hospitals
- **SE1036/Dec Physician RAC vulnerabilities**
- SE1037 /Jan 11 Guidance on Hospital Inpt Admission (referencing CMS guidelines, does not mandate Interqual/Milliman, RAC judgment allowed)
- **SE1104/Mar 11 Correct Coding for POS/Physician**



# CMS Identified 2 High Risk Areas for Physicians from RAC Demo, SE 1036

## Two areas of high risk were identified: (Automated)

- **Services with excessive units** (units exceed the # of units per day based on the CPT code descriptor \$6,635,558-pending appeal)
- **Duplicate claims** (billed and paid for two claims for the same beneficiary, for the same date of service, same CPT code, and same physician, \$1,094,751 – pending appeal)



# CERT Audit Focus

- Based on CERT audit results/ West coast, the following were targeted for audit:
  - 99214
  - 99223 (Initial day)
  - 99233 (Subsequent hospital visit)
  - Cert audits can trigger requests for records if provider history shows an abnormal volume/risk for targeted CPT codes
  - H&P complement the inpt status decision



# E&M Risk Analysis

- Closely monitor the E&M bell curve
- If peer group comparison data is available, use it
- If not available, request from the professional association for the specialty
- Continue to monitor as a high bell curve is an 'easy target' for audit.



# Assign the Correct Levels.....

- Don't go down the under coding road as it can easily be seen as 'enticement' to undercharge to get business.
- Document to support the level of care that was billed...



# CMS Project Officers Contacts

- **Region A (DCS)**
  - [www.dcsrac.com](http://www.dcsrac.com)
  - [info@dcsrac.com](mailto:info@dcsrac.com)
  - 1-866-201-0580
  - *CMS RAC Contact: Ebony.Brandon@CMS.hhs.gov*
- **Region B (CGI)**
  - <http://racb.cgi.com>
  - [racb@cgi.com](mailto:racb@cgi.com)
  - 1-877-316-7222
  - *CMS RAC Contact: Scott.Wakefield@CMS.hhs.gov*
- **Region C (Connolly)**
  - [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC)
  - [RACinfo@connollyhealthcare.com](mailto:RACinfo@connollyhealthcare.com)
  - 1-866-360-2507
  - *CMS RAC Contact: Amy.Reese@CMS.hhs.gov*
- **Region D (HDI)**
  - <http://racinfo.healthdatainsights.com>
  - [racinfor@emailhdi.com](mailto:racinfor@emailhdi.com)
  - 1-866-590-5598 Part A
  - 1-866-376-2319 Part B
  - *CMS RAC Contact: brian.elza@CMS.hhs.gov*

CMS assigns a project officer to each RAC. Use if abuse of the SOW or other issues are occurring.



# Questions and Answers

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