RAC AUDITS  
2011

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Disclaimer

This course was current at the time it was written. The materials are offered as a tool to assist the participant in understanding how to ensure that code selection decisions are accurate as a means of improving correct coding and avoiding post payment risk. Every reasonable effort has been made to assure the accuracy of the information within this presentation. Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary between payers.
Where Did RACs Come From?

Medicare Modernization Act, section 306
- Initially a three-year demonstration project
- Tasked with recovering overpayments and identify underpayments
- Payment to auditors on a contingency fee basis

Three states selected initially based on highest Medicare utilization:
- California
- Florida
- New York

Tax Relief and Health Care Act of 2006, section 302
- Expanded to all states in 2010
- Mandated by Congress

The Impact of RAC Legislation

$10.8 billion in improper Medicare payments were identified in 2007

New approaches by the Government were taken to safeguard the Medicare program
- Comprehensive Error Rate Testing (CERT) program produced error rates and estimates of improper payments to evaluate CMS contractors and program performance.
- CMS uses this data to identify problems and target audits
- The Error Rate Reduction Plan identifies strategies to clarify CMS policy and implement new initiatives for reducing improper payments
The CMS RAC Program Mission

Detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments.

Providers can avoid submitting claims that do not comply with Medicare rules.

CMS can lower its error rate.

Taxpayers and future Medicare beneficiaries are protected.

Limits to Provider Burden

CMS limits the RAC “look back period” to three years.

Maximum look back date is October 1, 2007.

RACs will accept imaged medical records on CD/DVD.

Limit the number of additional documentation requests.

Maintain transparency.
RAC Contractors

Bids went out for contractors

CMS hired independent contractors - Recovery Audit Contractors (RACs) - to audit

Four final permanent contracts were hired to cover specific regions

Four Regions-Four RAC Contractors

Region A: Diversified Collection Services (DCS)
Region B: CGI
Region C: Connolly, Inc.
Region D: Health Data Insights, Inc.
RAC Regions…in the Beginning

- **Region A** - Diversified Collection Services, Inc. of Livermore, California, in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York
- **Region B** - CGI Technologies and Solutions, Inc. of Fairfax, Virginia, in Michigan, Indiana, and Minnesota
- **Region C** - Connolly Consulting Associates, Inc. of Wilton, Texas, Connecticut, in South Carolina, Florida, Colorado, and New Mexico
- **Region D** - Health Data Insights, Inc. of Las Vegas, Nevada, in Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona

More About RACs

Claims are always reviewed **post-payment**

The same Medicare policies utilized as Carriers, FIs and MACs: NCDs, LCDs and CMS manuals

Two types of review:

- Automated (no medical record) – most common
- Complex (medical record required)

RACs are required to employ staff consisting of nurses, therapists, certified coders, and a physician.
RAC Audit Issues

RACs select issues to review based on data mining techniques, Office of Inspector General (OIG) and GAO reports, CERT reports, and the experience and knowledge of staff.

New issues for review approved by CMS will be posted to RACs’ Web sites. (see your region)

RACs will be able to look back three years from the date the claim was paid.

2010 RAC – The First Year of Auditing

2010 was the first year of RAC audits
All states are now eligible for RAC audits
$1.7 billion in Medicare claims were audited
  • $86 million in claims were denied (5.5%)
The First Year - Continued

Larger facilities are statistically more likely to be audited first.

Initial information is still somewhat limited.

70-80% of audits are NOT appealed.

30% (approximately) that have been appealed are still in process.

2010 Additional Documentation Requirements (ADR)

Institutional Providers

- 1% of Medicare claims submitted for the previous calendar year divided into eight periods (45 days).

Based on TIN and Zip Code

Professional Services and DMEPOS Suppliers

Two Caps existed in FY 2010

- Through March 2010, the cap was 200 ADR per 45 days for all providers/suppliers.
- From April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per TIN) will have a cap of 300 ADRs per 45 days
Examples from CMS

Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.

Provider B has TIN 123456780 and has two physical locations in ZIP codes 12345 and 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

Record Limitations

For more information, please see:

RAC Audit Findings – So Far

Over 95% of RAC audits identified overpayments that have been linked to:
- Incorrect payment amounts
- Incorrectly coded services (including medical necessity services)
- Duplicate Services

Before a RAC Can Audit

CMS must approve all audit issues prior to audit

Approved audit issues are posted to RAC website

Review your region’s website continually
- Some issues are ongoing/open-ended
Different Types of Audits

• Automated – the RAC’s determinations are made without the medical record
  • Outpatient Billing Errors
  • Inpatient Coding Errors
  • Duplicate Payment
  • Outpatient Coding Error
  • Incorrect Discharge Status
  • Other

The CMS Strategy - RAC

Automated Review-Black & White Issues
DRG Validation-complex review
Coding Error Review – complex review
DME Medical Necessity Reviews –complex review (calendar year 2010)
Medical Necessity Reviews-complex review (calendar year 2010)
The RAC Collection Process

Same as for Carrier, FI and MAC identified overpayments
Carriers, FIs and MACs issue Remittance Advice
Remark Code N432: “Adjustment Based on Recovery Audit”
Currently superseded by other remark codes; system fix anticipated in April 2010
Carrier, FI, MAC recoups by offset unless provider has submitted a check or a valid appeal

Provider Options Post RAC Audit

Pay by check
Allow recoupment from future payments
Request or apply for extended repayment plan
Appeal
Appeal Timeframes
• 935 MLN Matters
Different Types of Audits

Complex – the medical record is reviewed by the RAC auditor team

Human review by approved personnel (nurses, coders, physicians, etc)

- Records are requested from providers
- Typically records are electronically submitted
    - Follow RAC instructions for submitting

Medical Necessity Review

- All four RACs were authorized to begin in August 2010
- Complete data from audits is not available yet
- See your contractor for current information
- Audits and recoveries are increasing
Audits Are Increasing

Increased audits results in increased costs to providers
Additional RAC audit programs may be added in the future
Medicaid – audits delayed
Medicare Part C – coming
Final rule expected late in 2011 with new audit information

Transparency

New issues are posted to the web
Major Findings are posted to the web
RAC claim status website
Detailed review results letter sent following all complex reviews
Ensuring Accuracy of the RACS

RAC Validation Contractor provides annual accuracy scores for each RAC

If a RAC loses at any level of appeal, the RAC must return the contingency fee

CMS follow RAC statistics on recoveries and appeals

Steps to Prepare Now

Know your practice
Know your providers
Conduct self audits or hire independent auditors
Have an Education Plan
Have a Compliance Plan
Stay current on documentation and coding
Monitor the RAC websites
Maintain a documentation file
What Else

Be prepared to appeal if claim can be defended.
If there is a dispute, physicians have the right to:
• Discuss findings with RAC representatives
• Appeal RAC findings
Obtain guidance from an attorney experienced in health care law prior to appeal.
Assign a point person to manage the appeals process and RAC request for records.
There are restrictions on sample size based on size of practice.

Audit Tips

Assign one point person to handle all audits
Communication and consistency are key
Knowing how and when to respond to an audit
Watching key time frames
Don’t miss deadlines
Be thorough with responses
Negotiate and cooperate
Know when to appeal, when to pay
Learn from mistakes, don’t repeat them
Prevention Tips

Look to see what improper payments were found by the RACs:

- Demonstration findings: www.cms.hhs.gov/rac
- Permanent RAC findings: will be listed on each RAC’s website

Look to see what improper payments have been found in OIG and CERT reports

- OIG reports: www.oig.hhs.gov/reports.asp
- CERT reports: www.cms.hhs.gov/cert

Audit Findings - Prevention

Not documented – missing or incomplete documentation – common audit finding, and very avoidable

Medical necessity not established - what was the reason for the visit, and was it documented sufficiently?

Charting 101 - patient name, date of service, provider name
Audit Findings

Incorrect code – wrong code or supporting documentation
Timed Units – review for documentation supporting ‘time’
Diagnosis code/severity not properly coded or documented
Non-covered services – what is considered investigational or not payable?
Watch for new services, equipment – verify this is a covered services and coded correctly

Medical Necessity Reviews

• Started in August 2010
• Does the medical record document what was done and how sick the patient was?
• Does your EMR help you or hurt you?
  – Watch for canned or cloned notes
  – Does each visit accurately document the reason for the visit that day for that patient?
  – Watch for documentation carried over patient to patient or from previous visit
  – Is documentation pertinent to that visit **that day**?
Know What RACs Can Ask For

Single practitioner: **10** records every 45 days
Two to five practitioners: **20** records every 45 days
Six to 15 practitioners: **30** records every 45 days
Large group (16+ practitioners): **50** records every 45 days

Disputing and Audit

- If there is a dispute, physicians have the right to:
  - Discuss findings with RAC representatives
  - Appeal RAC findings
- Be prepared to appeal if claim can be defended
  - Do you need to consult with a certified coder/auditor?
- Seek counsel from an attorney experienced in health care law prior to appealing
If You Appeal the RAC Audit

The appeals process:
First Level:
 Redetermination from intermediary/carrier
 Reconsideration from qualified independent contractor (QIC)
 Administrative law judge appeal
 Medicare department appeals board
 Federal district court appeal

Level Two Appeal

• Conducted by a QIC
• You must file within 180 calendar days of receiving notice of redetermination decision.
• QIC has 60 days to respond.
• Practice must submit full presentation of evidence with rationale for disagreement of redetermination.
  • One shot to submit - cannot submit information later
  • Practice should produce all supporting evidence
  • Evidence not submitted might be excluded at subsequent levels
• Minimum monetary threshold not required.
Level Three Appeal – Administrative Law Judge

- If at least $120 remains in disagreement
- You can make request within 60 days of receipt of QIC reconsideration
- Handled through hearings at more than 140 Social Security offices around the country
- Most hearings will be by video-conference equipment or telephone

Level Four Appeal

- 60 days to request a review of an ALJ decision.
- Medicare Appeals Council (MAC) review must be completed within 90 days of receipt of a request, with some exceptions.
- MAC is supposed to consider only evidence in the record considered unless a new issue is raised on appeal.
- The parties have no right to a hearing at the MAC level; may request an oral argument.
- Generally, a MAC decision is prerequisite for proceeding with an appeal in federal court.
Level Five – Federal District Court

- You must have an attorney.

- A physician or patient who is not satisfied with the council’s decision may request a hearing.

- Request must be within 60 days.

- Amount of the appealed claim must exceed $1,220.

Responding to Audits

**Check the date** that you must respond.

**Ask for a reasonable extension** if you need one.

**Inform the practitioner of the audit** - ongoing

**Carefully select** the appropriate records to send along with all supporting documentation.

**Know** when to ask for help from:

- Practitioner
- Certified coder, auditor, or practice manager
- Attorney
How to Respond to the Audit

Most RAC audits are electronic - follow exact instructions.

- Include information pertinent to the medical record:
  - Along with the progress note for that day, was a flow sheet also updated with a change of medication, or a review of systems updated?
  - Was medical necessity for that test documented in a prior note?
- Send this even if the auditor doesn't ask for the information.
- Be detailed and organized.

Communication

Inform your RAC of the exact address and contact person they should use when sending additional documentation request letters.

If necessary, check on the status of your additional documentation (Did the RAC receive it?).

Log on to the RAC website to track receipt of information.
Don’t Procrastinate!

• Respond timely! You usually have a short time frame of 30 days to respond.
• Some records may take longer to obtain such as hospital records.
• If the auditor wants office records only, then copy and send the records promptly.
• Always review what you are sending and keep an exact copy for your records.
• Make sure your response is organized and legible.

Written Response to the Audit

• Describe your practice, your practitioners, and their credentials and any additional training.
• Include any sub-specialty information.
• Describe the condition the patient presented with that day, the ongoing care, procedures or services performed, the outcome, how the patient responded. Include patient information from previous visits if helpful.
• Include current expert opinions in an addendum.
• Make sure your sources agree with your treatment.
• Don’t be afraid to ask for help with this critical step!
Overpayments

• If the practice identifies overpayments (recoupments), it must issue a refund check.
• If Medicare identifies them, the physician receives a refund request letter.
  – Physician has 30 days to refund
  – After 30 days, interest begins accruing and offset is initiated
• Practice may request payment plans for recoupment/repayments in excess of $1,000.
• Practice must send overpayment even during the appeals process.

Issue Example from CMS

**Issue Name: Wheelchair Bundling**
Description: Bundling guidelines for wheelchair bases and options/accessories indicate certain procedure codes are part of other procedure codes and, as a result, are not separately payable.
Provider Type Affected: DME
Date of Service: 10/01/2007 - Open
States Affected: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
Additional Information: Additional information can be found in the following manuals/publications:
Example: Home Medical Supplies

- 2011 documentation requirements
  1. A dispensing order
  2. Signed and dated detailed written prescription
  3. Medical records that substantiate the detailed written prescription

  - Failure to maintain or supply this documentation will result in a recoupment request!

More Examples of Audit Focus

- **Legible signatures** on prescriptions and medical records is another area of focus
- The Medicare Program Integrity Manual indicates that a “legible identifier” in the form of a handwritten or electronic signature is required.
- For more information, see:
2011 Emerging Trends

Lysis of Adhesions
DRG mis-coding
Pre-admission testing
Follow RAC websites for emerging issues and trends

Summary

• Prevention is key to avoiding stressful and costly audits.
• Understand your practice.
• Stay current with coding and documentation guidelines.
• Conduct self audits or hire auditors.
• Follow your Compliance Plan.
• Monitor the RAC websites – not just your region.
• Understand the process; reduce the fear.
• Be Prepared – have a plan.
RAC Contact Information

Region A: Diversified Collection Services (DCS)
www.dcsrac.com
info@dcsrac.com
Region B: CGI Federal
http://racb.cgi.com
racb@cgi.com
Region C: Connolly Healthcare
www.connollyhealthcare.com/RAC
RACinfo@connollyhealthcare.com
Region D: HealthDataInsights (HDI)
https://racinfo.healthdatainsights.com
racinfo@emailhdi.com

CMS RAC Information

CMS RAC Website: www.cms.hhs.gov/RAC

CMS RAC Email: RAC@cms.hhs.gov
Thank you!