EHR Client Bulletin:

CMS Recovery Audit Prepayment Review Demonstration Updates

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On Thursday, August 9, 2012, CMS hosted an Open Door Forum call for providers to share updates and clarifications surrounding the CMS Recovery Audit Prepayment Review Demonstration, which will begin on August 27, 2012. The following provides some background on the program, key highlights from the Open Door Forum, resources available to providers, and best practices for how to prepare for the upcoming Demonstration. If you have additional questions on the Demonstration, please contact your Director of Strategic Accounts.

**Background on the Demonstration:**

According to a notice on the agency’s website, the Centers for Medicare and Medicaid Services (CMS) will launch its Recovery Audit Prepayment Review Demonstration on August 27, 2012. The three-year demonstration was announced in November 2011, and its original January 1, 2012 start date was subsequently delayed in response to provider concerns regarding administrative burdens.

This new demonstration program was created by the Centers for Medicare & Medicaid Services (CMS) to prevent improper payments before they occur, instead of recovering funds after they have already been distributed. The Recovery Audit Prepayment Review program will affect 11 states – seven with “high populations of fraud- and error-prone providers” (CA, FL, IL, LA, MI, NY, and TX) and four with “high claims volumes of short inpatient hospital stays” (MO, NC, OH, and PA).

According to the CMS website, the “RACs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments.”

**Updates/Clarifications Given During the CMS Open Door Forum:**

- The Demonstration will take place between August 27, 2012 through August 26, 2015.
- The 11 states included in this Demonstration are CA, FL, IL, LA, MI, MO, NC, NY, PA, OH, and TX.
- Only short-stay inpatient claims will be reviewed. CMS has defined short-stays as 1-2 day stays.
- The Recovery Auditors (RACs) will target the originally published MS-DRGs, however, they will be phased in throughout the first few months of the Demonstration:
  - August 27: MS-DRG 312 SYNCOPE & COLLAPSE
  - TBD: MS-DRG 069 TRANSIENT ISCHEMIA
  - TBD: MS-DRG 377 G.I. HEMORRHAGE W MCC
  - TBD: MS-DRG 378 G.I. HEMORRHAGE W CC
  - TBD: MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
  - TBD: MS-DRG 637 DIABETES W MCC
• TBD: MS-DRG 638  DIABETES W CC
• TBD: MS-DRG 639  DIABETES W/O CC/MCC

CMS will communicate when new MS-DRGs will begin through its Demonstrations webpage and its Twitter account, @CMSGov.

• If CMS sees a decrease in the error rate associated with a particular MS-DRG throughout the Demonstration, an MS-DRG may be removed from the approved list and replaced with a different MS-DRG.

• RACs and MACs will not be permitted to execute prepayment review of the same MS-DRGs or the same claims. Also, any claim reviewed during this Demonstration will be off limits in the future to any other CMS contractor conducting post-payment reviews, including Zone Program Integrity Contractors (ZPICs). These claims will still be available to the Department of Justice (DOJ) and the Office of Inspector General (OIG).

• The Additional Documentation Requests (ADR) will be sent from the Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC). The ADR will specify which address to send the documentation. This address may change so providers must pay special attention to the address provided.

• Limits on prepayment and post-payment reviews won’t typically exceed current post-payment ADR limits.

• The timelines and deadlines associated with this Demonstration are as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline/Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>FI/MAC Issues ADR to Provider</td>
<td><em>At this time, it is not clear on how long it will take to receive an ADR following a claim submission.</em></td>
</tr>
<tr>
<td>Provider Submits Documentation to RAC</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>RAC Renders a Decision, Communicates to the MAC, and Provider Receives Determination Letter</td>
<td>Within 45 calendar days of RAC’s Receipt of Documentation</td>
</tr>
<tr>
<td>Claim Will Be Paid to Provider If No Determination Is Reached</td>
<td>After the 45th calendar day</td>
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</tbody>
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• Providers maintain the same appeal rights as with post-payment RAC reviews, however, providers will not have the opportunity to engage in Discussion and must proceed to the first level of appeal, Redetermination. CMS is open to suggestions from providers on how it could possibly include Discussion in the appeals process. Providers can email CMS with suggestions at RAC@cms.hhs.gov.

• Review Results Letters should be sent to the person listed as the hospital’s RAC Coordinator. If the hospital would like to change the key contact for prepayment review correspondence, it should contact the RAC directly.
Additional clarification and answers to questions raised during the recent Open Door Forum will be posted to the Demonstrations webpage sometime the week of August 13, 2012. Providers should check the webpage regularly for additional updates.

Resources and Key Contacts for Providers:

THE CMS CERT Webpage:  
http://go.cms.gov/cert-demos

The CMS Demonstration Webpage:  

Slides from CMS Open Door Forum on RAC Prepayment Demonstration:  

CMS Twitter Account:  
http://twitter.com/CMSGov

CMS Email Address:  
RAC@cms.hhs.gov

Best Practices for Providers To Prepare for the Prepayment Demonstration:

• Ensure the hospital has a strong Utilization Review process in place to conduct a concurrent review of all targeted MS-DRGs. If the case does not meet first-level screening criteria for an inpatient admission, ensure a second-level physician review is conducted. As always, the quality of documentation will be key to validating the hospital’s admission decision and in supporting a strong argument in the appeals process, if an appeal is necessary.

• Assess your hospital’s process for receiving and processing all ADRs to ensure the specified timelines dictated by CMS will be met.

• Make sure that the hospital has a strong process in place to receive all review results and denial correspondence and to evaluate if an appeal is warranted after receiving a denial. Appeal all appropriate cases that the hospital feels have been inappropriately denied by the RAC.

• Track timelines closely to make sure the hospital is being paid on any claims in which a determination is not made by the RAC within the specific 45-day deadline. After the 45th calendar day, contact your MAC immediately to investigate the status of payment. If the hospital encounters issues, communicate the feedback to CMS. Hospitals should also collaborate closely with their state hospital association.
• If EHR manages your hospital’s appeals, submit the required documentation for appeal as soon as the hospital receives the notice of denial. As long as EHR can identify that the denial is a prepayment denial, our team will prioritize these appeals filings in an effort to help expedite the appeals process. Hospitals can note the denial as a prepayment denial by checking the “Pre-Payment Rev.” box on the EHR Denial Cover Form. The most updated EHR Denial Cover Form can be downloaded from the EHR Compliance Library or click here.

• If you would like to check on the status of an appeal, log into the EHR Exchange or contact EHR’s Appeals Management team at appealsupport@ehrdocs.com or (866) 873-5029.

EHR will continue to advocate strongly for our hospital clients through the Medicare appeals process and additional avenues. If you have additional questions regarding the Prepayment Demonstration, please contact your Director of Strategic Accounts who will be happy to coordinate a call for you with one of our experts.