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Medical Records Briefing

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RAC update

Permanent RAC program changes and new Medicaid program and pre-bill audit demonstration under way

Just when you thought you had your RAC processes in place, more changes appear on the horizon.

CMS wasn't shy about making changes to the Medicare RAC program in 2011. For example, the second half of the year saw demand letters shift to become the responsibility of Medicare Administrative Contractors (MAC)—a change that went into effect January 3, 2012.

As a result, when a RAC finds an improper payment, it will submit claim adjustments to the MAC, and the MAC will then establish receivables and issue automated demand letters, following the same process it uses to recover any other payment.

The change is detailed in *MLN Matters* article *MM7436 (www.cms.gov/MLNMattersArticles/downloads/MM7436.pdf)*.

Updated RAC Statement of Work

CMS then updated the final RAC Statement of Work in September, and instituted a few other changes providers should note. (View the Statement of Work at *www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf.*)

One of the biggest changes affects the RAC discussion period, which must now be conducted in writing instead of in an oral format. In addition, the use of the discussion period now is affected by the appeal process. If the provider files an appeal while in the discussion period, it effectively ends the discussion period and the appeal timelines go into effect. Providers will have to pay attention to this change and refrain from beginning an appeal until the discussion is concluded, or else forgo the discussion period and move straight into the appeals process.

"Hospitals need to be prepared to manage the complex appeals process," says **Joseph Zebrowitz, MD,** executive vice president of Executive Health Resources in Newtown Square, PA. "As time has progressed, the percentage of appeals overturned at the early levels has decreased, though the overall overturn rate is still extremely high. The hope is that CMS would take this information and streamline the appeals process for providers. Until that happens, however, hospitals need to have excellent infrastructure, tracking, and most importantly an attitude of persistence to ensure they are reimbursed appropriately for care provided."

The Statement of Work also introduces the concept of semi-automated reviews and reiterates that RACs may find partial overpayments. While this is not a change, per se, CMS suggests RACs should deny any overpayments but permit payment for a lower-paying medically necessary level of care.

Medicaid RAC final rule

CMS released the final rule on the new Medicaid RAC program in September, as required by section 6411 of the Affordable Care Act. (View the final rule at *www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.*) While modeled after the federal Medicare RAC program, the Medicaid version will be run by each individual state.

The final rule, which is effective January 1, 2012, provides guidance to individual states related to federal and state funding for startup, operation, and maintenance costs of the Medicaid RACs.

The rule also discusses the need for an adequate appeals process for providers that may dispute an adverse determination, and directs states to coordinate with other contractors, entities auditing Medicaid providers, and state and federal law enforcement agencies. Each state will have several choices to make regarding payment methodologies, documentation request limits, and other program details.

"The concern here is that some states serve many Medicaid patients from bordering states, so providers need to be aware of that state's Medicaid RAC processes

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as well as their own," says **Debbie Mackaman, RHIA, CHCO,** regulatory specialist for HCPro, Inc., in Danvers, MA. There's already a lack of consistency between the Medicaid programs, she says, and RACs only add to the increasing regulatory burden for providers. Mackaman notes that although there are some standard program requirements, each state's Medicaid RAC may create its own "rules of engagement."

New pre-bill demonstration program

In November 2011, CMS announced further initiatives to reduce improper payments, including a new RAC pre-bill auditing demonstration project.

The Recovery Audit Prepayment Review demonstration will take place in 11 states that tend to have either fraud- or error-prone providers, or a high volume of short inpatient stays (i.e., California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas).

The demonstration project, set to begin in January 2012, will allow RACs to look at claims prior to payment to verify that providers are complying with payment rules, and to prevent erroneous payments in the first place instead of looking for those that have already been made.

"This demonstration project could prove to the providers' advantage," Mackaman says. "Since the review will be done within the timely filing limitations, providers will be able to file corrected claims, when appropriate, to receive a payment without going through the appeals process. This should also reduce the paid claims error rate since the review is done prior to the payment."

Interestingly, another initiative was announced by CMS along with the one for the pre-payment RAC audits: the Part A to Part B rebilling initiative. This volunteer-based program will allow a sample of hospitals to rebill for 90% of the Part B payment after a Medicare contractor (e.g., a MAC, CERT, or RAC) denies a Part A inpatient short stay as medically unnecessary because the care occurred in the wrong setting. (Currently, the entire claim would be denied in full.) CMS expects this demonstration to lower the appeals rate for denied claims.

Beneficiaries will be held harmless for any cost sharing that would occur as a result of shifting coverage for services from Part A to Part B, Mackaman notes. "If the patient would pay more as an outpatient than they did as an inpatient, the hospital could not charge the difference, and vice versa," she says. Still, there's a lot to clarify before providers rush to sign up, says Mackaman. For example, participating hospitals cannot file an appeal or retroactively bill for observation.

Additional information on this demonstration is forthcoming. Visit *www.cms.gov/CERT/02_Demonstrations.asp* for more details, and watch for upcoming FAQs on the CMS website. ■

FY 2011 fourth quarter RAC update

CMS released the latest information on the RAC program findings in its fiscal year (FY) 2011 fourth quarter report (available at *www.cms.gov/Recovery-Audit-Program/Downloads/FY2011QtrlyReport.pdf*).

According to the update, RACs identified $277.1 million in overpayments and $76.6 million in underpayments in the fourth quarter, and a total of $939.4 million in incorrect payments throughout the entire year. The update also identifies the top issue for each RAC region, all of which were medical necessity issues:

- Region A: Renal and urinary tract disorders
- Region B: Surgical cardiovascular procedures
- Region C: Acute inpatient admission neurological disorders
- Region D: Minor surgery and other treatments billed as inpatient

Notably, the RAC for Region C, Connolly, identified nearly as much in underpayments as overpayments ($60.7 million in underpayments vs. $65.2 million in overpayments). The other three RACs combined identified far fewer underpayments, approximately $16 million.

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