RACs and Beyond

Kristen Smith, MHA, PT
Senior Consultant, Fleming-AOD

Peter Thomas, JD
Ron Connelly, JD
Christina Hughes, JD, MPH

The Powers Firm

LTRAX.COM
Objectives

- Describe the various types of Medicare Contractors
- Explain the process/focus for each type of Medicare Contractor
- Review focus areas in LTACHs for Medicare audit activity
- Provide preliminary preparation tactics
LTACHs: Are we at Risk?

Medicare Total Costs: LTACH

Source: Medicare Cost Reports; Analysis conducted by Fleming-AOD, Inc.
MedPac

- March, 2013 Report to Congress
  - Variation of presence/utilization across the country
  - Patient criteria
- Continued stance to enforce both 25% rule and patient criteria

LTACHs: Are we at Risk?
Medicare Contractors

- Medicare Administrative Contractors
- Recovery Audit Contractors
- Comprehensive Error Rate Testing Contractor
- Zone Program Integrity Contractor
- Universal Program Integrity Contractor
Medicare Administrative Contractors

- MACs perform pre- and post-payment reviews
- Pre-payment review:
  - Claim is reviewed prior to adjudication
  - Can be random or focused
    - Provider based
    - Service based
  - Failure results in claim denial and no payment
  - Denied claims may be appealed
Medicare Administrative Contractors

• Post-payment review
  – Claim is reviewed after adjudication
  – Can be random or focused
    • Provider based
    • Service based
  – Failure results in claim denial and recoupment of payment
  – Denied claims may be appealed
  – Often triggered by other events
    • CERT audit results
    • OIG reports
    • CMS bulletins
Recovery Audit Contractors (RACs)

- Now referred to as “Recovery Auditors”
- Focused on recovery of overpayments and underpayments
- Only Medicare contractor that is paid on a contingency fee basis
  - Contingency fee ranges from 9.5% to 12.5%
  - Highly incentivized to recover improper payments
  - Must return payments if claims are reversed on appeal
RAC Structure

- Regional
  - Jurisdiction A: Performant Recovery (previously DCS)
  - Jurisdiction B: CGI Technologies and Solutions
  - Jurisdiction C: Connolly Consulting Associates
  - Jurisdiction D: HealthDataInsights
- Most of the primary contractors were involved in the 3-year demonstration project on RACs
- Subcontractors also involved, with oversight by primary contractors
RAC History

- Medicare Modernization Act (MMA) created a three year RAC demonstration project that resulted in $700 million in recoveries in 5 states
- Tax Relief and Healthcare Act of 2006 authorized a permanent nationwide RAC program
- Almost $5 billion in recoveries since expansion of the RAC program
RAC Demonstration

- Demonstration project ran from March 2005 through February 2008, with extensions granted
- Primarily in CA, FL and NY. Heavy focus on inpatient rehabilitation hospital claims
- Numerous issues arose during demo leading to contracting with independent organization for validation of California RACs performance
- Validation audit led to temporary hold on reviews, CMS-ordered re-reviews of certain claims, and agreements to return fees for cases overturned on appeal
RAC Demonstration

- California RAC overturned many denials following the re-review
- Majority of California RAC denials overturned by ALJs on procedural grounds related to “reopening”
- On remand, many of these cases were overturned based on medical necessity grounds as well
- Powers gained extensive experience with RAC demo appeals as legal counsel to over 50 clients with over 3,000 separate cases ranging from $7,500 to $45,000
- Extrapolation cases ranged from $4.2 to $10.4 million
Permanent RAC Program

• Congress permanently extended RACs and applied them to all 50 states and Medicaid

• Congress moderated most egregious aspects of RAC demo but left many factors the same
  – Example: RAC keeps percentage of recovery but only if not overturned at any level of appeal

• CMS has more oversight now than under demo
Permanent RAC Program

- Congress created an independent contractor, the RAC Validation Contractor, to oversee the RAC program
- The rollout began with “automated” reviews and progressed to “complex” reviews (i.e., medical record reviews)
- All topics for review must be approved by CMS
Current RAC Jurisdictions
Changes to RAC Assignments

• Since October 2012, some providers have been assigned a RAC other than the one generally overseeing their jurisdiction

• Any provider not located in Jurisdiction 5 who has WPS as their A/B MAC is automatically assigned to HealthDataInsights

• This change occurred due to completion of a new MAC contract transition to avoid having the same entity as both MAC and RAC for a provider
RAC Validation Contractor

• Involved in approving new areas for RACs to review
  – Conducts final review of proposed new issues
  – May recommend changes to proposed new issues (e.g., scope, methodology)

• Involved in oversight of the individual RACs’ auditing techniques and determinations
RAC Audits

• Three-year “look back” period
• Subject to limits on number of Additional Documentation Requests (ADRs) they can send to a single provider/supplier per 45-day period
• Required to pay for costs of submitting medical records
  – $0.12 per page + first-class postage
  – $25 cap on provider reimbursement for each medical record
The “Look Back” Period

• RACs may only look back three years to reopen claims
• The permanent RACs are explicitly required to comply with CMS’ “reopening” regulations
• All reopenings that occur after one year following the initial determination must be accompanied by a showing of “good cause”
RAC ADR Limits for Hospitals

- 2% of total claims for previous year, divided by 8 (to account for 45-day periods)
- “Per campus” – facilities with the same TIN and first three positions of ZIP code
- Maximum of 400 ADRs per 45-day period, except for very high-volume Medicare providers (more than $100 million in annual MS-DRG payments)
- Only 70% of total ADRs may be focused on one claim type (e.g., IRH/U claims)
- Permission to exceed these limits may be granted
Approval of “New Issues”

• New Issue Review Board made up of mostly clinicians (i.e., nurses and one physical therapist)
• RACs required to maintain lists of the issues that they are targeting on their websites
• Issues must be approved independently for each region
• RAC Validation Contractor gets final say
RAC Update

• Potential transition coming, with new contracts being awarded
• RACs soon required to cut off ADRs until new contracts awarded and transition complete – Nov. 15, 2013
• New ADR limits for hospitals published in August 2013
• Automated and semi-automated reviews do not count towards ADR limits
  – Automated reviews do not involve medical records
  – Semi-automated reviews
    • Providers permitted, but not required, to submit medical records
    • 3 of 4 RACs have issues involving semi-automated review of IRFs
Comprehensive Error Rate Testing

• Purpose is to measure the performance of the contractors
  – Establish the claim payment error rate
  – Used to evaluate the efficiency of the contractors
• Still result in overpayment/refund request for providers and suppliers
• Can lead to systematic auditing by the contractor
Zone Program Integrity Contractors

- ZPICs established in 2008 to replace Program Safeguard Contractors (PSCs)
- Segregated into 7 zones
- Focused on identifying and preventing fraud and abuse
- If the ZPIC calls, there is generally more risk than calls from the RACs or MACs
ZPICs

- Post-payment reviews only
- Review usually triggered by:
  - Referral from primary contractor or RAC
  - Government reports identifying vulnerable areas
- Will repeatedly audit on slightly changed criteria
- Frequently use extrapolation
Unified Program Integrity Contractors

- UPICs – new contractor being developed by CMS
- Request for Information issued by CMS – initial stages only
- Designed to replace ZPICs and Medicaid Integrity Contractors (MICs to be phased out)
- Will take over program integrity responsibilities of MACs
  - MACs will retain payment processing responsibilities
  - Unclear how much auditing authority MACs will retain
- To operate on a regional basis
- Will not replace RACs
Reopening Claims

- Reopening occurs when claims are reviewed after having already been paid
- Permissible at any time within 1st year, but must meet certain standards after that:
  - “Good cause” must exist for reopening claims more than one year after payment
  - After 4 years, no reopening may occur unless there are allegations of fraud
  - BUT RACs may only reopen claims for up to 3 years
“Good Cause” for Reopening

• “Good cause” exists when:
  – There is new and material evidence that was not known or available at the time of payment or
  – The evidence available at the time of payment shows on its face that an error was made

• However, medical records, if not previously submitted to the reviewing entity, can be “new and material evidence” for purposes of satisfying the “good cause” standard under the manual guidance

• Medicare contractors routinely ignore the requirement for “good cause”

• Not challengeable at the ALJ or federal court level
Extrapolation

• Contractor must identify a “sustained or high” error rate or failure of documented education to correct a payment error

• “Sustained or high” error rate not actually defined by CMS

• Providers may not appeal a determination that an error rate is “sustained” or “high”
  – May appeal contractor’s failure to make one of the required findings
  – May appeal finding of failed education
Extrapolation (cont’d)

• Providers may also appeal individual claims denied and methods used by the contractor in constructing and/or analyzing the sample
• Consider involving experienced Medicare counsel and/or independent experts
GAO Report on Contractors

- Issued in July 2013
- Determined that the overlap and inconsistency between the contractors may impede efficiency and effectiveness while doing little more than increasing the burden on providers
- Recommended a full review of post-payment review requirements and processes in order to streamline the process, eliminate redundancy and increase effectiveness
- Report may have been impetus of decision to create UPICs
What to Do When CMS Calls

• With proof of identity, permit them to enter the premises and examine the files they wish to see.
• Alert in-house counsel, if applicable, and chief executive.
• Inquire as to their objective, their timeline, and what stage of the process they are in.
• Cooperate fully and be as helpful as possible.
• Keep copies of anything they take from your files and mark them for future use, if need be.
• Perform self-audit on same files and consult legal counsel with expertise in Medicare if necessary.
Preparing for Audits

- Develop your audit team, including a point of contact with responsibility for all communications with auditors of any kind
- Prepare your medical records staff/department
- Pursue self-audits to assess compliance with existing documentation and medical necessity requirements
- Create a systematic response to contractor audits including case tracking and strict adherence to timelines and deadlines
Medical Records

• Track electronic notices such as remittance advices (time deadlines are linked to these notices)
• Alert billing and collections staff of importance of remittance advices
• Develop and manage a system for tracking submission of records, including proof of contents, mailing and delivery
• Develop system for maintaining medical records in accessible format
• Develop system of tracking contractor requests to compare against requests by other contractors and against any limits on requests
Education and Internal Audits

• Purposes:
  – To allow for preparation/maintenance of medical records that may be requested
  – To identify vulnerabilities for purposes of proactive responses, including education and/or repayment

• Carry out internal education of clinical, coding and billing staff based on Medicare guidance to avoid audits in the future

• 60-Day Rule: There is an obligation to disclose to Medicare any overpayments that are discovered in the course of a self-audit within 60 days of identification of an overpayment
Tips for Successful Audits and Appeals

1. Don’t Assume that the Medicare Contractor Knows What It Is Doing
2. Prepare Now, Not When the Contractor Comes
3. Don’t Miss Deadlines for Appealing Denials
4. Make Effective Use of Every Stage of Appeal
5. Write Effective Appeal Letters (e.g., use layperson’s language, no acronyms, and make a persuasive case)
Interrupted Stays
- Included in OIG FY 13 Work Plan
- Focus on improper payments in CY 2011
- Attention on readmission patterns directly following the interrupted stay periods

Short Stays
- Did patient require LTACH admission vs. continued stay in STAC and/or alternative setting?
Medical Necessity

- Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007
  - LTACHs only admit high acuity medically complex patients
  - LTACH patients are discharged to less costly Medicare settings (IRF, SNF, etc.) as soon as they no longer require LTACH services
- MACs hired to audit medical necessity in 2008 (Advance Med and Wisconsin Physician Services)
Medicare Claims

- Reconciliation of your documentation and coding
  - Overpayments
  - Improper Payments
Questions?

ksmith@ltrax.com
Peter.Thomas@ppsv.com
Ron.Connelly@ppsv.com
Christina.Hughes@ppsv.com

Next Call: December 5, 2013
Documentation Preparation and Prevention