BECKER'S ASCREVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

RAC Readiness

October 29, 2011

PACE Healthcare CONSULTING

Agenda

1. Introduction
2. Description of RAC
3. New CMS Statement of Work
4. Non-Compliant Case Study
5. How To Be Compliant
6. Appeals Process
7. Questions and Answers

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RAC is Billing Compliance

- While we focus on RAC in this presentation, the real focus is overall billing compliance.
- Being RAC compliant means you collaborate between **revenue cycle and clinical documentation** to support all billing claims or appeals of any kind.
- Will also correct for under billing.

RAC's Mission

- Detect and correct **prior improper payments** so that FIs, MACs, and carriers can prevent future improper payments (3 year look back)
- Providers can avoid submitting claims that do not comply with Medicare guidance
- Centers for Medicare and Medicaid Services (CMS) can lower their error rate
- Taxpayers and future Medicare beneficiaries are protected
- The original statement of work can be found at: http://www.cms.hhs.gov/rac/downloads/Final%20RAC%20SOW.pdf
  - Contains all the contractual information regarding what the RACs must perform and what shall be excluded from their scope.
  - Necessary to have on file and to have read thoroughly

RAC Demonstration Project

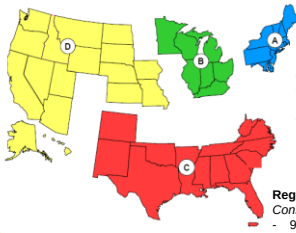
- Collected $1.03 Billion in Overpayments
- Cost of Program $201.3 Million or .20 cents on the Dollar
- Incentive to Make Permanent

RAC Regions

- Four Recovery Audit Contractors, one for each region, each with their own subcontractor

Region B: *CGI*
- 12.50% contingency fee
- http://racb.cgi.com/issues.aspx?st=1

Region D: *HealthDataInsights (HDI)*
- 9.49% contingency fee
- https://racinfo.healthdatainsights.com/Public/NewIssues.aspx



Region A: *Diversified Collection Services (DCS)*
- 12.45% contingency fee
- http://www.dcsrac.com/issues.html

Region C: *Connolly Consulting*
- 9.0% contingency fee
- http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

Permanent RAC Program

- Four RAC Auditor/Regions
- Each Submit Issues to CMS for Approval
- Approved Issues are Posted to Website
- May Request Additional Reviews Approval from CMS During Audit
- Self Disclosure of Issues Prevents RAC from Auditing Those Claims

September 12, 2011

CMS Releases New Statement of Work for RAC

New RAC Statement of Work

- *Now Recovery Auditor (RA) Instead RAC
- *Additions and Clarification Includes *All* Contracts, Types of Claims Not Just Acute Care Facilities'
  - **ASCs Named specifically**
- Addition of "semi-automated reviews" to Include Complex and Automated - No Payment for Record Submission
- Change to RA Website Listing of New Issue List Must be Sortable by Minimum Provider Type
- *CMS Reserves Right to Share New Issues with all CMS Review Entities
- *Clarification of RA and MAC Roles

Source:www.racmonitor.com Vicki-Axsom Brown

What Else is Happening with RAC in 2011?

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The RAC Goal was to Recoup another $1B by end of 2011

Shortfall of $82.5M thru 3rd Quarter 2011

Only $225M/Quarter has been Recouped

RAC Recoupments have increased successively by quarter

RAC Must Collect $307.5M in 4th Quarter to make up the difference

All providers are moving to MAC's as FI by 2012

According to Washington: **No providers will be spared**

The goal is to view claims across providers and deny a group of claims

Able to follow A, B, C, D across episode of care thru MACs

Physician – ASC communication will be vital under MACs

http://www.racmonitor.com/news/3-feature-aritcles/624-racs-fall-short-in-third-quarter-by-825-million.html
http://www.cms.gov/Recovery-Audit-Program/Downloads/NatProg.pdf

Third Quarter 2011 **Going Forward** **Affecting All Providers**

New for 2012

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All States Required to Have Medicaid RAC in Place by January, 2012

Review Types of RAC Audits

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Automated

- Has been the focus for 2011 RAC audits
- Performed through each RAC's proprietary software
- No request for records when the RAC is reviewing claims for trends that may indicate an incorrect payment
- Looking for instances of incorrect coding leading to overpayments or underpayments on the part of the practice
- Assume they are happening all the time on all cases billed in the last three years
- May receive demand letter or only overpayment report

Semi-Automated

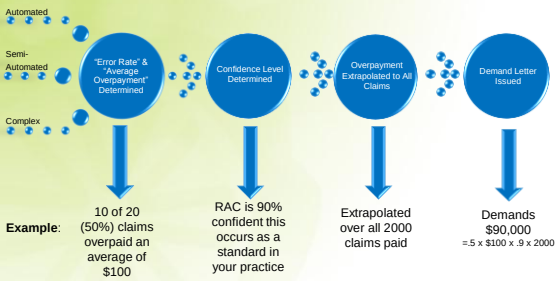
- Will begin like the Automated Review
- Requests medical records (MRs) and alerts of reason for review
- You will receive either a letter notifying you that the review is closed or a demand letter

Complex

- Similar to the semi-automatic review, requests for medical records will occur
- You will receive a results letter detailing the results of the review and a demand letter depending on the results

Extrapolation

Get Ready for Next Wave



RAC Performance

Average automated denial $401	Average complex denial $5,469
Automated denial most seen in the outpatient billing arena	90% of overpayments in third quarter 2011 were automated

http://www.cms.gov/Recovery-Audit-Program/Downloads/NatProg.pdf.
http://www.aha.org/aha/content/2011/pdf/Q4-2010-RACTrac-results-chartpk.pdf.

Where Are You Vulnerable?

Medically Unlikely Edit (MUE) Program

Physicians Most Vulnerable for Injections/Infusions	Unit of Service for Healthcare Common Procedure Coding System (HCPCS)	Services Rendered by Single Provider to Single Beneficiary on Same Date of Service	Determine How Many Claims You Have for These Types of Service Since October, 2007 or Three Year Lookback to Establish Risk

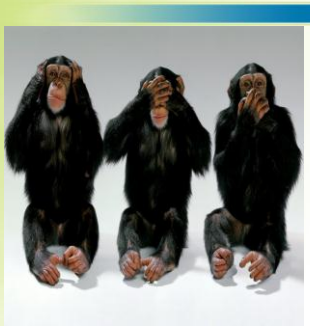
Risk Areas RAC/OIG Targets

- Physician Assistant & Nurse Practitioner not Following Billing Guidelines for Physician Presence
- Physicians Billing Place of Service Errors (Office vs. Surgery Center)
- Evaluation and Management Billed During Global Period
- Medical Necessity - Documentation Does Not Support Service

Other Risk Areas RAC/OIG Targets

- Pharmaceutical Coding - Incorrect Code or Units for Injections
- Stark Violations - Referring Patients to Services Physician or Physician Family Member Have Financial Interest In
- Duplicate Billing
- Debridement Coding - Surgical Vs. Wound Care

So What to Do?



Can't we just change our practice and move forward?

Are you proactive?

Or reactive?

Case Study Example

- A surgery practice of 5 physicians consistently billed for an assistant at surgery. The assistant surgeon was not medically necessary and did not perform any services during the surgery. This practice had been going on for many years.
- In 2003 the practice engaged an outside entity to conduct a compliance review of its billing practices.
- The practice immediately stopped seeing its Medicare and Medicaid patients.
- The practice did not conduct a retrospective review to determine the amount of Medicare and Medicaid overpayment received.
- The physician (that was not a shareholder in the practice) left the practice and reported the activity to the Government.
- Let's fast forward to October 2005…

- After a three year investigation:
  - Four cardiac surgeons specializing in complex heart bypass and transplant surgeries have agreed to pay the US $2.5 million to settle claims that their practice submitted false claims to federally-funded health programs, including Medicare and Medicaid, for the services of additional surgeons.
  - The practice agreed to enter a guilty plea to a five count misdemeanor indictment charging the practice 18 U.S.C. 641 violations involving theft of government services.
  - Two of the four surgeons entered into five year integrity agreements with the OIG and HHS to settle administrative claims. The remaining two physicians have retired from their surgical practices.

- The Moral of the Story:
  - Had the practice performed a retrospective review in 2003 and repaid the overpayments, the raid, the investigation, the fines, the criminal indictment, and the loss of medical licenses **could have been avoided**!!!!

Is Process Improvement Enough?

- Probably not
- Must get senior management to buy-in
- Culture and Philosophy predict the market place
- Ignore the chaos which will be created by improvement
- Organization must define successful outcome

You need a team

RAC DENIAL ASSESSMENT

- Clinical – Coding/Billing
- Compliance – Revenue Cycle

RAC IMPLEMENTATION

- Leader – Group Liaison
- Documentation-Tracking – Patient notification

Staff Realignment

- Move work load from back end audits and corrections to 100% compliance on front end
- Manpower devoted to concurrent chart reviews and documentation
- Relieves coding/appeals/bill holds on back end
- If RAC has difficulty finding trends in your organization—you have lesser risk saving huge man hours to respond to RAC

RAC Offense

DOCUMENTATION

- Medical documentation will be reviewed to determine that the services were medially necessary and billed correctly
- The Physicians ink pen/mouse are key instrument in economics of healthcare

Defend your clinical and fiscal integrity

- Gather information/intelligence
- Be strategic
- Plan and Assess
- Establish a plan for success
- Respond to change in a measured fashion

Uncertainty abounds in our environment

- Do you know your surgical volume for next month?
- Will you make your next months sales quota?
- Do you know tomorrows stock values?
- Do you know how long it will take to get to the airport?
- These are among our daily uncertainties and risks
- Risk is associated with uncertainty however risk can be subjective or objective, which do you choose?
- Control your destiny! Chose your outcome!

The OIG Work Plan - 2011

- Error Prone Providers
- Providers who have consistently submitted incorrect claims to the CERT program over the last four years
- Place of service errors related to Part B claims in ASC's & outpatient hospitals
- Coding and payment of E/M services
- E/M services in the global period

Are You Prepared for RAC and Other Billing Audits?

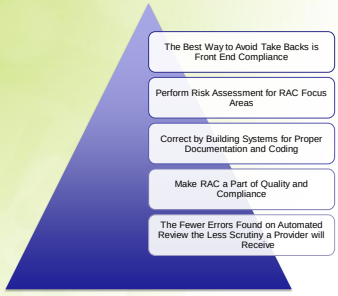
Sample Questions from Our Assessment

- Do you have an active chart audit committee?
- Do you have a RAC committee and/or a RAC Coordinator?
- Is your coding accuracy determined via independent audit as opposed to an internal review?
- Do you have a budget for RAC preparedness and response?
- Have you set aside a reserve for moneys to be used to payback CMS if appeals are unsuccessful?

RAC Strategies and Approaches

Proactive Preparedness for Providers

Make Yourself RAC Proof



Form ASC RAC Committee

- ASC Administrator, Chair
- Billing Manager
- Physician
- Scheduler
- Clinical Staff
- Registration
- Ancillary Staff

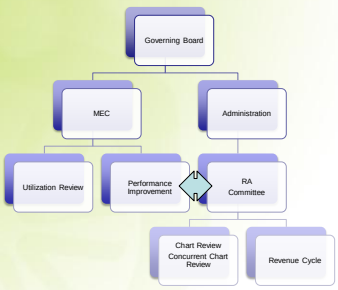
RAC Committee Responsibility

- Understand Rules for Billing
- Ensure Compliance with Billing
- Track and Trend Denials
- Regularly Check Your RAC Website
- Educate Office Staff and Physicians on Approved Issues and How to be Compliant
- Report RAC Activity to Governing Board

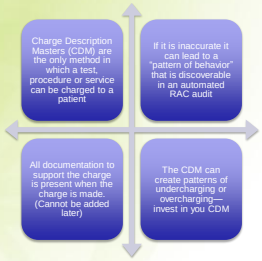
RAC Committee Responsibility

- Audit Charts/Billing for Approved Issues Prior to Dropping Final Bill
- Audit Concurrent Documentation for Completeness
- Train Registration Staff on Documentation
- Conduct Regular Coding Audits for Accuracy
- Report to Physician Leadership on RAC
- Manage Active Appeal Process

ASC Committee Structure



The Importance of Your CDM



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Preparedness Summation

- RAC Committee Essential to Manage Process
- Documentation is Only Way to Avoid Take-backs and Win Appeals
- Concurrent Chart Audits
- Finance and Clinical Have to Become Partners
- Shift Focus to Front End by Getting it Right the First Time
- Ensure the Chargemaster is Accurate

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Demand Letter and Appeals

Before the Demand Letter

- Be Proactive in Reviewing the RAC Website
- Use the Provider Contact Form Download on Website
- Have established communication pathways in preparation for appeals
- Document all Communication and Keep Records of Anything Sent to RAC
- Test your System - Send Yourself a Letter Using Your Contact Information to Ensure it Arrives and Staff Know how to Handle
- Consider a Separate Mailbox for RAC Correspondence

Connolly RAC Contact Information

Contact Information Form

Connolly Healthcare is the Region C Recovery Auditing Contractor for the CMS RAC Program. Connolly is requesting a contact person for both the potential recovery of underpayment/overpayment of claims, and for medical record request. After completing the below information, please fax to the attention of Christine Castelli, Principal of Connolly Healthcare, at the following fax number: 203.529.2995.

If you represent multiple facilities/providers, please complete a form for each facility/provider.

Provider Name: _____ Provider Number: _____ Tax Identification Number: _____ NPI #: _____ Mailing Address: _____ Is your facility a member of a group? Yes ____ No ____. If yes, please provide the following information: Group Name: _____ Medicare Group Number: _____ Group Mailing Address: _____ Group NPI #: _____

Contact for Potential Recovery of Underpaid/Overpaid Claims

Contact Person: _____ Title: _____ Mailing Address: _____ Contact's Telephone Number: _____ Fax: ( ) _____ Email: _____

CHECK HERE IF YOU WANT ALL CORRESPONDENCE, INCLUDING MEDICAL RECORDS REQUESTS, TO BE DIRECTED TO THE ABOVE INDIVIDUAL. OTHERWISE, COMPLETE THE NEXT SECTION.

Contact for Medical Record Request

Contact Person: _____

Title: _____

Mailing Address: _____

Contact's Telephone Number: _____

Fax: ( ) _____ Email: _____

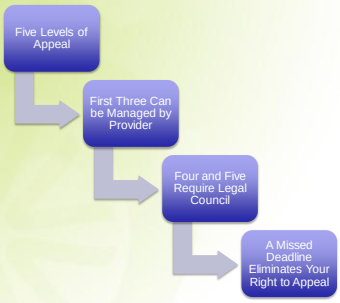
**If your contact person(s) changes, please update this form and resubmit to Connolly for processing.

Connolly Healthcare One Crescent Drive, Suite 300-A, Navy Yard Corp. Ctr. Philadelphia, PA 19112 Tel. 866.360.2507 – Fax. 203.529.2995

Source: Connolly Website

The Appeals Process

Levels of Appeal



Interest

- Interest is charged at 10.75% every 30 days
- Two ways this impacts providers
  - Interest due on repayments after 30 days from redetermination
  - Appealing RAC determinations
    - While going through appeals process interest will accrue on the amount under dispute
    - Can stop interest from accruing if appeal filed within 30 days
    - Interest will be removed if appeal overturned at any stage
    - If not overturned interest will be applied with the overpayment take back
- Sometimes better to repay than pay interest

racinfo@connollyhealthcare.com

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RAC Tools to Assist in Managing Process

Online Issues Database

- Keeps providers current on issues
- Allows for sorting and ease of use
- Reduces labor cost for issue tracking

RAC Tracking Database

- Keeps up with audits and appeals internally
- Notification on appeals deadlines
- Provides forms for appeals
- Provides management reports on activities and costs

Conclusion:

RAs are a permanent part of the landscape, but you can survive and thrive through good systems.

Questions and Answers

APPENDIX
Appeals Process Detail

Appeals
The RAC program does allow for providers to appeal to alternative authorities when they feel an overpayment judgment is unjustified. These appeals occur over several progressive levels:

- Discussion period allows for rebuttal to the RAC within 15 days (optional)[9,14]
- Level 1 appeal to Fiscal Intermediary within 120 days
- Level 2 Appeal to Qualified Independent Contractor within 180 days of Level 1 finding
- Level 3 Appeal to an Administrative Law Judge within 60 days of Level 2 finding
- Level 4 Appeal to the Medicare Administrative Contractor within 60 days of Level 3 finding
- Level 5 Appeal to the District Court within 60 days of Level 4 finding[9,14]

The Levels Of Appeal

- **First Level of Appeal: Redetermination**
  - A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination
    - [http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf]

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The Levels Of Appeal

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The Levels of Appeal

- **Second Level of Appeal: Reconsideration**
  - A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A Qualified Independent Contractor (QIC) will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration

The Levels of Appeal

- **Second Level of Appeal: Reconsideration**
  - Reconsideration should occur by the QIC in 60 days
  - QICs are:
    - Part A: Maximus, Inc
    - Part B:
      - North Jurisdictions – First Coast Service Options
      - South Jurisdictions – Q2 Administrators
  - Additional information on second level appeals can be found at:
    - http://www.cms.hhs.gov/OrgMedFFSAppeals/03_Reconsiderationby

The Levels of Appeal

- **Third Level of Appeal: Administrative Law Judge (ALJ) Hearing**
  - If at least $120 remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing

The Levels of Appeal

- **Fourth Level of Appeal: Appeals Council Review**
  - If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)
    - [http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf]

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The Levels of Appeal

- **Fifth Level of Appeal: Judicial Review in U.S. District Court**
  - If at least $1,220 (amount for 2009) or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review

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Appeals

- Develop letter or use CMS form with complete information which will be used at every appeal level (CMS Form on Connolly Web Site)
- Once the Information for Appeal is Submitted it Cannot be Changed
  - Additional information cannot be added later
  - Same tool will be used for Levels 1-3
  - Level IV and V use same information-different delivery process
- First and second level appeal is same process you use for managed care appeals
- Do not miss deadline for appeal
  - Develop tracking tool for internal use (Excel)
  - Track response deadline for RAC auditor as well

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Appeals

- Providers have 40 days
  - Letter or phone
  - Can ask to speak directly to "person" who initially denied
- Does not alter appeals timeline
- Is not a formal appeal
  - Won't stop recoupment
- Don't wait until the 11th hour…

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