The Law Offices of
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Health Care Provider
Legal Alert

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CMS Launches RAC Prepayment Review Demonstration

In This Issue:

As of August 27, 2012, recovery audit contractors (RACs) will examine specified Medicare program claims prior to authorizing payment. This is a noted departure from the incentive-based, post-payment audit program that currently exists. Recent legislation expanded the authority of Medicare Administrative Contractors (MACs) by eliminating provisions of the Social Security Act that imposed statutory limits on contractor use of random and non-random prepayment reviews.[1] The RAC prepayment demonstration will not interfere with MAC prepayment reviews, as neither contractor may overlap in reviewing claims already reviewed by the other contractor type. The Centers for Medicare & Medicaid Services (CMS) expects that prepayment reviews will curb fraud and abuse more efficiently than the traditional "pay and chase" audits of paid claims for errors.[2] Unfortunately, for hospital providers in the affected States, this could mean substantial delays in Medicare reimbursement.

Please feel free to reach us at the phone number or email address to the left if you have questions about this demonstration, how to prepare for claim reviews, or challenge payment denials on appeal.

Background. The Recovery Audit Program was made permanent by Section 302 of the Tax Relief and Health Care Act of 2006.[3] Under existing recovery audit programs, there are four regional RACs, responsible for identifying overpayments and underpayments made by the Medicare Program. RACs receive financial incentives for locating improper payments from CMS under their contingency fee payment structure. CMS proposed three demonstrations for 2012 in an effort to "[p]revent improper payments before they are made" and "[l]ower the error rate" for claims under the Medicare program.[4] The RAC Prepayment Review demonstration is part of the Recovery Audit Program.

The RAC Prepayment Review demonstration will run from August 27, 2012 to August 26, 2015, and apply to eleven States.[5] The seven States selected for being "fraud and error-prone" are: Florida, California, Michigan, Texas, New York, Louisiana, and Illinois; and the four States selected for high volumes of short inpatient stays are: Pennsylvania, Ohio, North Carolina, and Michigan. CMS hopes that prepayment review will improve providers' understanding of Medicare billing practices and documentation requirements.

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Affected States and DRGs. According to CMS, all eleven States were chosen because of "high improper payment rates."[6] CMS chose eight MS-DRGs for review during the first six to seven months of the demonstration.[7] They are:

- MS-DRG 312 Syncope & Collapse (beginning August 27, 2012)
- 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 (TBD)[8]

Initially, RACs will only review MS-DRG 312 (syncope and collapse) claims for improper payments.

Providers will be informed if a claim is suspended for additional review by a RAC. The provider will then receive an Additional Documentation Request (ADR) for medical records from its Fiscal Intermediary (FI) or MAC.[9] As with the current MAC prepayment review process, providers will have 30 days to submit their documentation. RACs have 45 days to complete their review of the claim, but the number of days for submission of the ADR response will not be counted, according to CMS.[10] Claims will automatically be denied if documentation is not submitted within 45 days. The RAC will review documentation that is timely submitted and make a determination on the claim. This payment determination will be communicated to the FI or MAC, who will then inform the provider.

Limits on prepayment reviews will not, in general, exceed current post-payment ADR limits.[11] Therefore, rather than reviewing 100% of the total incoming claims for a particular DRG, RACs will review a small percentage of those claims. CMS states that the RACs will not be able to use extrapolation techniques for prepayment reviews.[12] This means that providers will not be faced with outsized overpayment demands based upon a small sample of claims actually reviewed by the RAC.

Providers will have the same appeal rights for unfavorable determinations as they do under the current Medicare claims appeal process.

Preparing for Reviews. The RAC prepayment review demonstration poses new challenges for providers in the selected States. Although most Medicare providers are already familiar with post-payment claim reviews, and perhaps prepayment FI or MAC reviews as well, the incentives for RACs to identify payment errors on claims raises the likelihood that providers will face payment denials or adjustments as a result of this demonstration. The success of this demonstration will also help determine whether CMS expands RAC prepayment review to other States or implements a permanent program at the national level. Providers can take certain steps to better understand the prepayment review process and prepare for these RAC reviews.

A. Review the Medicare Program Integrity Manual for Guidance

Providers should familiarize themselves with Chapter 3 of the Program Integrity Manual (PIM) to be informed about the audit process.[13] This part of the PIM sets ground rules for Medicare contractors when conducting Medicare claim reviews as well as providers' responsibilities during those reviews. For example, where the RAC does not receive a provider's response within 45 days of the ADR, the RAC is instructed to "deny the claim, in full or in part, as not reasonable and necessary."[14] Providers can forfeit Medicare payments by failing to comply with these rules.

B. Make RAC Review Issues Part of Staff Training on Documenting, Coding, and Billing for Medicare Services

Providers already train personnel in Medicare program documentation and coding requirements. As always, Medicare services must be *documented as medically reasonable and necessary*. But RACs have a financial-based incentive to identify improper payments for claims, whether on the basis of a lack of medical necessity or improper coding and billing requirements. Therefore, RACs remain incentivized to deny claims for lack of proper documentation supporting a medically reasonable and necessary determination. Providers can make RAC review areas part of their training programs and materials to increase compliance.

In particular, for the DRGs now being reviewed as part of the demonstration, providers should focus on why the patient's condition required inpatient observation. CMS explained that it is targeting the above-mentioned DRGs because hospital providers are admitting patients for overnight observation, when outpatient observation would be more appropriate.[15] As one caller raised during the CMS Open Forum, a beneficiary's situation – taken in totality – may suggest the patient requires inpatient observation despite the fact that the risk identified in the initial assessment never comes to fruition.[16] According to the caller, in such scenarios RACs have denied the claims, seemingly viewing the claims through a results-oriented lens. To help avoid such payment denials, providers should ensure that medical records include documentation as to why the patient required inpatient observation.

C. Understand & Utilize Appeal Rights

As with more typical post-payment reviews, providers have the right to appeal unfavorable determinations from the RACs. Providers should be aware that the appeal window begins with the notice date on the claim denial, which often appears on a remittance advice (RA). There are strict deadlines at each level of appeal, from redetermination through Departmental Appeals Board (DAB) review. Please let us know if you have questions about this appeal process or need assistance with any appeals.

[1] *See* Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152 § 1302 (repealing Soc. Sec. Act § 1874A(h)).
[2] *See* Soc. Sec. Act § 1893(h) (describing the use of Recovery Audit Contractors in the Medicare Integrity Program established at section 1893). *See also* CMS Demonstrations Web site at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Demonstrations.html.
[3] Tax Relief and Health Care Act of 2006, Pub. L. 109-432, 120 Stat. 2992
[4] CMS RAC Prepayment Demonstration Slides, 2 (available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/downloads/RAC_Prepay_slides.pdf)
[5] *Id*. at 3.
[6] *Id*. at 2.
[7] CMS, Special Open Door Forum: Medicare Fee-for-Service Recovery Auditor Prepayment Review Demonstration (Dec. 21, 2011), 8. (available at http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/downloads/TransSODFRACPrePayRevewDemo122111Final.pdf) (hereinafter referred to as "CMS ODF for RAC Prepayment Demonstration").
[8] CMS RAC Prepayment Demonstration Slides, 4.
[9] CMS ODF for RAC Prepayment Demonstration, 7-8.
[10] *Id*. at 28.
[11] *Id*. at 7-8.
[12] *Id*. at 28.
[13] Medicare Program Integrity Manual (Pub. 100-08), Chapter 3 (available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf) (provides guidance for contractors, *e.g.*, MACs and RACs, reviewing claims for improper payments).
[14] *Id.* at *3*.2.3.8(A).
[15] CMS ODF for RAC Prepayment Demonstration, 13.
[16] *CMS ODF for RAC Prepayment Demonstration,* 27.

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.