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RECOVERY AUDIT CONTRACTOR (RAC)

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FACTS: RECOVERY AUDIT CONTRACTOR (RAC)

- Purpose of the RAC is to recover improper payments made to hospitals, physicians, etc.
- Demonstration project March 2005 – March 2008 in 3 states (New York, California, Florida)
- 3 more states were added in 2007
- Permanent program mandated by Tax Relief and Health Care Act of 2006
- Go live date is January 1, 2010 nationwide

The demonstration program was a success!

Facts: Total $ recouped = $979.9M

89% overpayments were to the inpatient hospital

Rest of overpayments to:

- Inpatient Rehabilitation Facility
- Outpatient Hospital
- Skilled Nursing Facility
- Physician
- Ambulance
- Durable Medical Equipment

Average loss per claim:

$442 Outpatient

$7,075 Inpatient

In Preparation for Permanent Program:

- US divided into 4 regions (A, B, C, D)
- Ohio is in Region B
- 4 Contractors chosen

Ohio’s RAC Contractor: CGI Technologies and Solutions, Inc.

November 2008 two unsuccessful contractors filed a protest: PRG Schultz, Viant Payment Systems

On 2/4/09 protests were settled, stop work order was lifted

PRG Schultz subcontractor for CGI to review Home Health, DME claims

First states in Region B are IN, MI, MN – March 1

Ohio start up August 1, 2009 or later

How does this affect me?

- Look back to 10/1/07
- Audit conducted looked “back”
- Today you must go forward
- Data Mining

CMS said: Improper Payments can Occur When:

- Payment is made for services not medically necessary
- Payment for services not correctly coded
- Failure to submit documentation when requested
- Other errors (i.e. duplicate claims)

Your Role

- Know the rules. Requirements for documentation, billing in NCD, LCD
- Follow the rules. Follow your own P/P
- Document and document correctly!
  - Coding is affected by documentation. Coding = reimbursement

RAC Medical Record Request Limits

- Inpatient Hospital, IRF, SNF, Hospice
  - 10% of avg mthly Medicare claims (max of 200) per 45 days
- Other Part A Billers (Outpatient Hospital, HH)
  - 1% of avg mthly Medicare services (max of 200) per 45 days

RAC Medical Record Request Limits

- Physicians
  - Solo Practitioner: 10 records per 45 days
  - Partnership of 2/5 ind: 20 records per 45 days
  - Group of 6-15 ind: 30 records per 45 days
  - Large Group (16+ ind): 50 records per 45 days
- Other Part B Billers (DME, Lab)
  - 1% of avg mthly Medicare <u>services</u> per 45 days

Inpatient Hospital, IRF, SNF, Hospice by NPI

- 10% of average monthly Medicare paid claims per 45 days
- Maximum of 200 medical records per 45 days
- Ex 1: Local Community Hospital
  - 1,200 Medicare paid claims in 2007
  - Divided by 12 = avg 100 Medicare paid claims per month
  - Times 10% = 10
  - **Limit = 10 medical records per 45 days**

Inpatient Hospital, IRF, SNF, Hospice by NPI

- Ex 2: Major Medical Center
  - 12,000 Medicare paid claims in 2007
  - Divided by 12 = avg 1,000 Medicare paid claims per month
  - Times 10% = 100
  - **Limit = 100 medical records per 45 days**

Outpatient Hospital, Home Health, Etc by NPI

- 1% of average monthly Medicare paid services per 45 days
- Maximum of 200 medical records per 45 days
- Ex 1:
  - 1,500 Medicare paid services in 2007
  - Divided by 12 = avg 125 Medicare paid services per month
  - Times 1% = 1.25
  - **Limit = 2 records per 45 days**

Outpatient Hospital, Home Health, Etc by NPI

- Ex 2:
  - 360,000 Medicare paid services in 2007
  - Divided by 12 = avg 30,000 Medicare paid services per month
  - Times 1% = 300
  - **Limit = 200 records per 45 days (capped at maximum)**

Physician (by NPI)

- Solo Practitioner
  - Limit = 10 medical records per 45 days
- Partnership of 2-5 individuals
  - Limit = 20 medical records per 45 days
- Group of 6-15 individuals
  - Limit = 30 medical records per 45 days
- Large group (16+ individuals)
  - Limit = 50 medical records per 45 days

Other Part B Billers (DME, Ambulance, Lab) by NPI

- 1% of avg mthly Medicare paid services per 45 days
- Maximum of 200 medical records per 45 days
- Ex 1:
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April 29, 2009 RAC FAQ 9716

Medical record requests necessary for complex reviews by the RAC are based on 2008 calendar year claim volume – not 2007 numbers.

QMCG PreRAC Audits

- Certain IP MS-DRGs
- Debridement procedure
- Heart Failure and Shock
- Respiratory System diagnosis with Ventilator
- OR Procedure Unrelated to PDx
- Septicemia
- Coagulopathy

Certain Outpatient Services

- Transbronchial Biopsy
- Speech Therapy
- Physical Therapy
- Neulasta, 6 mg
- Chemotherapy Drugs
- Wound Care (visit and procedure)
- Debridement

Medical Necessity

- OBS – medical necessity
- IP – medical necessity, 1-3 day stays

Inpatient MS-DRG Findings

- Change PDx
  - Follow Coding Rules
  - Availability of Discharge Summary
  - Physician Query
- Add/Change/Delete Secondary Dx
- Excisional Debridement

Outpatient Audit Findings

- Neulasta = J2505, 6 mg
- Administration of Neulasta
  - 96372, therapeutic IM injection
  - 96401, chemotherapy, IM
- Should be:
  - J2505, 6 mg = 1 unit
  - 96372

- Know that chemotherapy drugs are coded/ billed correctly
  - High dollar
  - High risk
- Is your pharmacy CDM accurate?

Therapy

97001 - PT Eval

97003 - OT Eval

- Preop Evaluation, billed
- Patient scheduled for joint surgery

Outpatient Physical and Occupational Therapy Services LCD

- Do not bill therapy screenings utilizing the evaluation codes. Screenings are not billable services.
- Evaluations for deconditioning after hospitalization where it is anticipated that prior functional abilities would spontaneously return through patient, caregiver and/or nursing activities are not considered medically necessary and are not covered.
- **Pre-operative evaluations performed routinely to ascertain the patient's post-surgical needs and/or to explain the services that will be provided post-operatively are non-covered. The patient's post-op experience and functional limitations are unknown prior to the surgery and will at that time require a new evaluation of the situation when medically necessary.**
- If treatment is given on the same day as the initial evaluation, the treatment is billed using the appropriate CPT codes. The documentation must clearly describe the treatment that was provided in addition to the evaluation.

Therapy

Re-evaluation 97002 listed on claim, performed approximately 30 days after start of treatment

Ex:

7/7/08 first treatment listed on claim

8/4/08 re-eval

Therapy

A re-evaluation is not a routine, recurring service. Do not bill for routine re-evaluations

Indications for a re-evaluation include:

- New clinical findings,
- A significant change in the patient's condition, or
- Failure to respond to the therapeutic interventions outlined in the plan of care

Other Examples – Physical Therapy

- CPT code 97035 = 8 min (1 unit)

+CPT code 97110 = 25 min (2 units)

TOTAL 33 min (2 units)

From LCD

Total the minutes for all timed modalities and procedures provided to the patient on a single date of service for a single discipline whether a single timed code service is provided or multiple timed code services, the skilled minutes documented will determine the number of units billed. Once the minutes have been summed, use the chart below to determine the total allowable units, based on total timed code treatment minutes

Minutes Chart

Units of Service	**Time Increments**
1 unit =	1 min to < 23 mins
2 units =	23 mins to < 38 mins
3 units =	38 mins to < 53 mins
4 units =	53 mins to < 68 mins
5 units =	68 mins to < 83 mins
6 units =	83 mins to < 98 mins
7 units =	98 mins to < 113 mins
8 units =	113 mins to < 128 mins
	Continue adding 15 minute increments as needed

Nursing, E.D.

- Drug Administration
  - Document start/stop times

90774, IV push, single or initial substance

90760, IV infusion, hydration, initial

- Follow coding rules: The initial code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.

Ex: Transbronchial biopsy – 31628

Fluoroscopy = 76000-59

CCI Edit 31628/76000

Do not report 76000

Wound Care

Review E&M Level and procedure

- 99215 documentation not supported, should be 99213
- First visit to Wound Care Clinic, pt evaluated, debridement done.

  Claim: 11041

Should be: E&M Level
11041

- ESA – Epoetin, Epogen
  - LCD
  - Medical Necessity
  - Billing Frequency

Value Code 48, Hemoglobin

Value Code 49, Hematocrit

Emergency Department E&M

CPT codes 99281-99285

Does your facility have a bell curve?

Insufficient Documentation

Some or None

Ex: ED record, no ancillary reports

DOS for therapy, no physician order, no Plan of Care, no Certification/Recertification

Physician Orders not signed

Medical Necessity

- ED marked IP, AP ordered OBS
- Change in patient's status retrospective
- Condition code 44

Changing IP status to OBS

Condition code 44

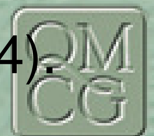
- Patient must still be in the hospital
- Hospital has not submitted a claim
- Patient's physician agrees with U.R. Committee's decision
- Attending physician documents his/her agreement with the U.R. Committee's decision in the medical record

- Determine patient's status upfront
- Consider: ED
  PACU
  Surgery Scheduling
- Case Management should be available 24 hrs/7 days/week

Appeals

- Five levels of appeal

1. Redetermination
   - Within 120 days from the date of receipt of the initial claim determination. Appeal to F.I.
2. Reconsideration
   - Within 180 days of receipt of redetermination (level 1). Appeal to Qualified Independent Contractor.
3. Administrative law judge hearing
   - Within 60 days of receipt of reconsideration (level 2).
4. Medicare Appeals Council
   - Within 60 days of the receipt of administrative law judge decision (level 3).
5. Judicial review in U.S. District Court
   - Within 60 days of the appeals council decision (level 4).



Appeals

- Not included in 15-day rebuttal. Optional step
- Deadlines for hospitals are strict
- RAC has as long as they want
- After reconsideration (level 2), no new additional information can be presented. Recommend getting legal and medical expert review before sending.

Questions?

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