

**CENTERS FOR MEDICARE AND MEDICAID (CMS)
RECOVERY AUDIT CONTRACTOR (RAC) PROVIDER OUTREACH**

Wednesday, October 28, 2009

QUESTIONS AND ANSWERS

1. **CMS:** Will CMS allow the RAC to review Maryland rate-regulated hospitals' charts for APR-DRG and APG coding accuracy?

CMS has not ruled out this possibility. DCS is still investigating whether they will be able to determine the amount of an improper payment should their reviewers find incorrect APR or APG coding.

2. **CMS:** Will CMS allow the RAC to perform automated reviews of Maryland rate-regulated hospitals' claims?

CMS has not ruled out this possibility. DCS and CMS recognize that the vast majority of audits of HSCRC regulated services will be by complex review to ensure the audits are compatible with the Maryland payment system.

3. **CMS:** Will CMS allow the RAC to review Maryland rate-regulated hospitals' claims for discharge status?

CMS will not instruct DCS on how to review. If it is necessary for DCS to review the discharge status, they will review it.

4. **CMS:** What process will CMS follow to determine whether an issue identified by the RAC applies to Maryland rate-regulated hospitals?

CMS has a new issue review panel. This review panel will seek input from the HSCRC and from Highmark, as needed.

5. **CMS/DCS/Highmark:** Please discuss your expected time line to complete the joint operating agreement between Diversified Collection Services (DCS) and Highmark, and to begin reviews at Maryland hospitals.

DCS expects to complete the joint operating agreement with Highmark by November 30. They expect to complete joint operating agreements with WPS, the other fiscal intermediary processing claims within the state before November 30. As to when hospitals can expect to begin receiving medical record requests, DCS expects reviews of Maryland hospitals to begin in late December or early 2010, and most likely later than that. CMS is not approving complex issue reviews until the RACs have experience with automated reviews, which they consider to be easier to determine whether payments are more clearly correct or incorrect.

Because CMS and DCS expect very little automated reviews in Maryland hospitals, audit activity is likely to occur later than in other areas.

6. **CMS/DCS:** Please review the time frames by which providers will be notified of favorable and unfavorable decisions after audits.

The RAC has 60 days to review medical records. If the RAC does not complete the review within 60 days, they may request an extension. CMS may or may not grant the extension. Neither CMS nor the RAC expects DCS to miss the 60 day window. Providers will receive notice of unfavorable results of a complex review via a “detailed review results letter” and via a “demand letter.” Providers will be notified of unfavorable results of an automated review via a “demand letter.”

7. **Highmark:** Please review the timing and process of RAC take backs and provider notifications. Please also address how the provider’s decision to appeal affects the notifications and take backs.

Information on appeal timeframes is at

<http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf>

Additional information on the 935 appeal process is at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf>

The appeal time frames begin from the date of the remittance advice which should correspond to the date of the demand letter.

8. **Highmark:** How will payments and interest be identified on the 835? What coding structure will be used?

Payments and interest will look like currently reported payments and interest. Remark code N432: “Adjustment Based on Recovery Audit” is the only identifier planned for use on the 835 at this time.

9. **CMS/Highmark:** Providers have raised concern that the majority of patient accounting systems do not post remark codes. Is there an adjustment code that could be used to ensure that the patient accounting systems incapable of posting remark codes are able to post the take backs? Does Highmark have discretion to add codes? Can this be addressed before take backs begin?

Highmark does not have the flexibility to develop additional claim adjustment codes that could be used to identify RAC-related take-backs. CMS’s central office is working with the American Hospital Association on this issue. It is not clear when a resolution will be reached.

10. **CMS:** What happens if the Medicare Administrative Contractor (MAC), or Qualified Independent Contractor does not meet their appeal review time lines?

The time frames are a performance standard in the contractors' contracts. While CMS will not take any immediate action, failure to meet contractual performance standards will reflect unfavorably on a contractor when a contract is up for renewal.

11. **CMS/DCS:** If DCS requests a medical record for review and then is not able to review it within the 60 days, can they re-request the same record?

No, the RAC has 60 days to review medical records. If the RAC does not complete the review within 60 days, they may request an extension. CMS may or may not grant the extension. Neither CMS nor the RAC expects DCS to miss the 60 day window.

12. **CMS:** When a claim denial is overturned on appeal, can the MAC re-audit for another reason?

The RAC cannot re-audit, but another contractor, such as the MAC can re-audit. This rarely happened in the demonstration project. When it did occur, the claim was denied by automated review, the provider won the appeal, re-submitted the claim and it hit a different edit.

The RAC enters into the RAC data warehouse all claims it reviews to ensure they do not re-audit the claim. The MAC and other contractors also enter all claims they've audited into the RAC data warehouse to ensure the RAC does not re-audit claims that have already been reviewed. Because each audit contractor has access to the RAC data warehouse, there should be no lag in updating the information.

Providers that choose to extrapolate the results of a self-audit should keep a record of all claims that have been included in a pay-back based on extrapolation. Although the MAC accepts the pay-back, the individual claims are not reviewed and are not entered into the RAC data warehouse.

13. **CMS:** For providers with multiple National Provider Identifiers (NPIs), does the 200 claims in a 45-day period, per NPI still apply?

Yes, however, CMS will apply the 200 claim limit to providers with multiple NPIs housed on a single campus. CMS is re-negotiating the claim limits for the next federal fiscal year which begins on October 1, 2010. CMS expects to redefine claim limits by tax ID number.

14. **CMS/DCS:** Please review the logistics of submitting medical records both on paper and electronically via CD and secure Web site.

DCS will accept medical records in paper or electronic formats. DCS recommends providers submit in electronic format because all paper documentation will be scanned upon receipt. Due to CMS security requirements, DCS is unable to accept protected health information via the web. Providers that store all or part of the medical record electronically may need to supplement the information generated by their systems to ensure that all necessary documentation and clear images are sent to reviewers. In addition, provider may choose to attach notes to documentation or images with a contact name, number and email address where the reviewer can request a higher resolution image or other technical help if needed.

15. **Highmark:** How will Highmark handle adjustments for periods that have already been settled for facilities receiving periodic interim payments?

RAC claim adjustments will be handled the same as normal adjustments for Maryland Waiver hospitals that receive Periodic Interim Payments (PIP) for inpatient services. The bi-weekly PIP payments are estimated interim payments. The actual claims and adjustments are accumulated in the CMS PS&R system and the PIP payments are adjusted to actual after the yearly cost report is submitted by the provider and a final settlement is performed by HMS.

16. **CMS/DCS:** If DCS were to extrapolate error results, how would it work and what types of claims errors would be extrapolated?

Although extrapolation is permitted in the scope of work, DCS does not intend to use extrapolation, at least initially. If DCS chooses to extrapolate, they will follow the Medicare Integrity Program rules. These rules can be applied to any type of error.

Providers that choose to extrapolate the results of a self-audit should keep a record of all claims that have been included in a pay-back based on extrapolation. Although the MAC accepts the pay-back, the individual claims are not reviewed and are not entered into the RAC data warehouse.

17. **DCS:** What role will your subcontractor, PRG-Schultz, play, if any, in the RAC program at Maryland acute care hospitals?

PRG-Schultz is the subcontractor for MAC region 14. In Maryland, PRG-Schultz is also the home health and hospice subcontractor. Only providers in those areas will have contact with PRG-Schultz.

18. **DCS:** Please discuss the process by which DCS will review for medical necessity. Please include the types of decisions nurses will make, when a case is referred to a physician, and the guidelines or other criteria used throughout the process.

The contractor medical director is responsible for the clinical integrity of all the audits. Reviewers will closely follow Medicare national coverage determinations, local coverage determinations, and the Medicare Internet Only Manual. The experienced and trained nurse, coder, and therapist reviewers will follow pre-determined criteria which will include decision control points where they must turn the decision-making to a physician reviewer. The criteria and decision making process does allow for the trained reviewers to deny a claim without physician review. In addition, physician reviewers oversee the work of all non-physician reviewers.

Providers that have based decisions on reputable peer-reviewed material can introduce this material on appeal.

19. **DCS:** Please describe the “discussion period” and the types of issues DCS expects to resolve during this process. Will the hospital contact a specific person at the RAC? Is there a format to follow?

Providers can call the phone number on the demand letter or use a form that will be posted to the DCS Web site. Examples of issues that could be handled during the discussion period include providers requesting more information on why a claim was denied, or alerting the RAC that the provider failed to send critical documentation with the initial medical record and is sending additional information. The discussion period does not affect the appeal timelines.

20. **CMS/DCS:** Please discuss how audits for services related to the hospital stay will be affected by a hospital medical necessity denial. Please specifically address skilled nursing facility claims when a three-day qualifying stay is denied, and physician claims following a medical necessity denial.

On a SNF claim, the RAC will not automatically review it because it would result in a beneficiary liability and the RAC scope of work does not include beneficiary liabilities. The MAC could choose to review the SNF claim. In the case of physician services, the RAC could review the physician claim, but will not automatically review the physician claim.

21. **CMS/HSCRC/Highmark:** When an inpatient admission is denied because the services could have been performed as an outpatient, will the entire billed amount be retracted, or only the admission and room and board (Part A) charges? If the entire billed amount is retracted, can the provider re-submit a 121 or 131 bill type for the Part B charges?

The entire amount will be retracted. There are criteria under which providers can re-bill the services under Part B. One of the criteria is that the re-billing must occur before the expiration of the timely filing deadline. The Centers for Medicare and Medicaid Services website (IOM- 100-04/Chapter 4 Section 240) includes clear instructions for re-billing medical admissions as inpatient Part B (on a 12X type bill). Re-billing surgical admissions on a 13x-type bill requires the provider to notify the patient along with several other criteria.

Detailed instructions are not yet available on the Highmark Web site. Kim Droboniku promised to get this direction for providers before the end of this calendar year as it is the next timely filing deadline.

22. **CMS/HSCRC/Highmark:** If the denial occurs beyond the time period in which the provider can re-bill, will providers lose the entire amount of the charges even though necessary services were performed at the appropriate level (e.g., Emergency services prior to the admission, or a surgical procedure that would have been paid as an outpatient)?

Yes, this is true. The CMS Office of General Counsel believes a statutory change would be required to allow providers to re-bill for these services. For this reason, CMS is delaying approval of complex reviews.

23. **CMS/DCS:** Please discuss units-related retractions. For example, if a hospital bills two units and the RAC determines the hospital should have billed one unit, will the RAC take back the charges related to both units or one? If the charges for both are taken back, will the hospital have to appeal for the one unit or simply do an adjusted claim with the one appropriate unit? If the RAC takes back the charges for one unit, will the amount be determined by simply taking back half of the billed amount for the two units?

Because of the way charges are developed under the Maryland payment system, simple arithmetic cannot be used to determine the amount of improper payment in an example such as this. Additional discussion and research will be needed to determine whether and how situations such as this will be handled.

24. What forums are available for discussion and resolution of ongoing issues?

The Maryland Hospital Association (MHA) will join the hospital associations in the other Region A states on monthly conference calls with DCS. In addition, DCS and MHA will hold conference calls as needed to discuss Maryland-specific issues. Providers can contact Traci La Valle at tlavalle@mhaonline.org to raise Maryland-specific issues.