Busy Year for the RACs

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Learning from last year's denials and preparing for what's ahead will help providers avoid being stung in 2012.

When the Recovery Audit Contractor (RAC) permanent program began in 2009, providers were hopeful that the process for identifying underpayments and overpayments would offer resolution from missing letters, unwarranted denials, unclear next steps in the process, and the disjointed flow of the RAC demonstration program. There remained, however, a level of uncertainty and hesitation about what was to come. As we enter 2012, it is clear that many areas of the permanent program still leave providers searching for answers and help.

Meanwhile, the program continues to expand. The Medicaid permanent program began in January, and three demonstration projects will launch this year (Part A to Part B rebilling, prepayment review, and prior authorization of power mobility devices). The new programs put an additional burden on providers.

Let's review the RAC program over the past year; investigate what has been revised, updated, and implemented; and take a look at what is to come with the new initiatives.

RAC Focus Items

The four Medicare RACs currently have 1,614 issues posted, and this number changes regularly. Issues are areas in which the contractor can perform reviews on what may be problematic from a coding, billing, or medical necessity standpoint.

Each Medicare RAC is required to post its issues so providers are aware of the focus items in their region. These issues are for providers of inpatient and outpatient services, physician services, professional services, home health, durable medical equipment (DME), and ambulance services. Denials for lack of medical necessity (wrong setting) and DME have topped the list of denials over much of 2011, according to the Centers for Medicare and Medicaid Services (CMS).[1]

In reviewing Comprehensive Error Rate Testing (CERT) data from the 2010 report, released in November 2011, the DME supplier error rate was the highest of all the areas reviewed-74 percent of 82,000 claims reviewed.2 These errors were related to missing physician orders and diagnostic laboratory tests.

An additional issue in the 2010 report has resulted in a demonstration project in 2012: missing or incomplete documentation of the face-to-face examination for power wheelchairs. Denials for lack of medical necessity (because of inappropriate or wrong setting) also had a notable error rate. CMS stated:

> Based on a review of the claims in error, CMS determined that there were 2,453 inpatient hospital claims in the CERT sample totaling $25.1 million in actual overpayments where the claim was denied in full because the services provided were not medically necessary as an inpatient service and should have been provided as an outpatient service. These inpatient hospital errors project to $5.1 billion of improper payments in the Medicare universe. The projected net difference between what was called an error and what may have been payable had the service been billed in the appropriate outpatient setting was $3.2 B, or a difference in the error rate of -1.5 percent; 9.0 percent rather than 10.5 percent.[2]

Resolving Documentation Errors

Further review of the CERT report shows that providers are struggling with submitting complete and appropriate documentation for review and justification of the services provided. Outpatient hospitals had more documentation issues than any other type of provider, at 74 percent. Physician services and DME led the healthcare industry in insufficient documentation errors by clinical setting. This is an error we need to focus on and learn more about as providers.

Performing a documentation assessment within clinical areas can help identify gaps in translation, documentation, and delivery of appropriate information to justify an encounter. Centralizing the organization's audit response process by assigning dedicated staff with specialized knowledge (internally or externally) can improve responses and identify and resolve process inefficiencies.

Questions to ask in resolving documentation errors include:

1. Have we validated that the documentation requested has been sent to satisfy the medical record request?
2. Has charge detail validation been performed and confirmed through documentation review? This process can be time consuming; however, as justification of services billed becomes more crucial, this can be a key step in ensuring you are not overlooking key information that may be needed or identification of a problem area overlooked in the past.
3. Are the professionals responsible for this release trained appropriately, and do they understand the significance and importance of what is being sent?
4. Are there records housed (on paper or electronically) in satellite areas that we are unaware of?
5. Do the professionals in charge of releasing the records have access to all the needed documentation, or is information hidden or inaccessible?

The CERT reports provide insight into where problematic areas lie. Utilize this report to take a closer look at your documentation and assess where you are. It is sometimes apparent that key players are not involved in the review of requests and denials. Ensure everyone is kept aware of an audit's status as it relates to their area. Also take a look at additional documentation requests you receive from CERT as well as other review agencies to learn where your shortcomings may be and to recognize where you are doing well.

Updated Statement of Work

An updated RAC statement of work (SOW) released September 1, 2011, further explained some key areas in the RAC program. One area was semi-automated reviews.

Providers started to see these types of reviews prior to the release of the SOW, and many providers relied on their RAC or hospital association to assist them in determining how to respond. Semi-automated reviews are identified through an automated review process and based on unlikely billing scenarios that raise suspicions of incorrect billing. For example, they may occur with CPT codes with modifiers such as 25. Organizations should ensure they review all semi-automated denials to justify codes submitted as billed and follow through with documentation to prevent denial. There have been many instances in which these accounts have to be reviewed case by case, and the automated denial status is not foolproof.

Another area that has rendered much conversation is DRG validation versus clinical validation.

Clinical validation, as described in the SOW, "involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. Clinical validation is beyond the scope of DRG [coding] validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."[3]

Common coding areas where clinical validation has been problematic for providers are sepsis, pneumonia, and renal failure. Having a strong interdisciplinary team that includes a coding professional with strong clinical knowledge, documentation specialist, and physician advisor is critical here. As the extent of coding or clinical knowledge can be individualized, it is important providers review these types of denials carefully and use team members or physician advisors to assist in discussion or appeal of the case.

If a strong documentation improvement specialist is not on your RAC team, you may want to add one. This person can help better prepare for clinical validation from an audit standpoint and an ICD-10 perspective. This can include education on

specificity in documentation and consistency of diagnoses within the medical record to reflect the true clinical picture of the patient.

Providers must work through solutions to clinical validation, because it is likely here to stay. Use these types of denials as teaching opportunities for both the provider and the RAC.

Discussion Period

Despite skepticism about the success of the RAC discussion period, many providers across the nation, as well as the American Hospital Association (AHA), have reported the process has been very successful. Based on AHA RACTrac 3rd quarter 2011 data, 34 percent of providers reported reversing denials during the discussion period.[4]

As described in the SOW, providers are allowed this time, and they should use it regularly. (To learn more about the discussion period, see "RAC Forensics 101, Part 1," in the February 2011 issue.) Work closely with your case management or utilization review staff, physician advisors, and coders to create a process that makes the discussion period work for your organization. We are all aware of how time sensitive this process can be and the amount of follow-up needed to stay on top of current account status; however, using the discussion period effectively can pay off in the long run.

Appeals

Based on the AHA RACTrac data, providers appear to continue to do well on appeals. Providers have overturned approximately 77 percent of claims submitted for formal appeal (see "RAC Forensics 101, Part 2" in the March 2011 issue for additional information on the appeal process).

Financial Reconciliation of RAC Accounts

Financial reconciliation continues to be a problem for providers, as many are determining whether to allow immediate offset, pay by check, or allow recoupment. As they have had the opportunity to review the process and the 835 electronic remittance advice detail, providers have found that reconciling the information back to a specific account can be difficult.

CMS has stated it is aware of the problem and is working toward solutions, such as adding the account number to the PLB segment to allow providers to easily reconcile the financial detail, along with any interest, back to the specific patient.

Part A to Part B Rebilling Demonstration

The Part A to Part B rebilling demonstration initiative will allow providers to surrender all appeal rights, excluding discussion, for the opportunity to resubmit Part A medical necessity (wrong setting) denials as Part B outpatient (excluding observation payment and self-administered drugs). This will allow providers to be paid at 90 percent for these services.

This demonstration began with review results letters dated January 1, 2012. Organizations that have not been notified by now that they were selected for participation likely will not be taking part.

Many providers chose not to participate due to the questions they had about the denials they may receive, request volumes, and reconciliation of monies, to name a few.

Organizations that are participating can consider the following processes:

Part A Denial Process

- Review account and perform discussion (follow cases closely)
- If case not overturned by day 30 (or as determined by the individual organization), pay by check, allow recoup, or perform immediate offset
- Inform coding staff of the need to rebill, using outpatient coding guidelines as appropriate and coding any procedures as necessary
- Involve team in removal of charges related to observation, self-administered drugs

- Review for addition of CPT charge detail as needed for conversion to outpatient claim
- Resubmit bill as 13X within 120 days of denial and following payment receipt or recoupment

Ongoing Process Improvement for All Part A Participants

- Develop an improved utilization review process concurrently for short-stay DRGs
- Consider performing a short-stay review using the utilization review team post-discharge
- Determine need to review and re-establish admission criteria for certain target short-stay DRGs
- Educate coders on review and coding of short-stay records
- Educate coders on key areas that may need to be coded to assist in justification of admission from a data-mining standpoint, such as valvular heart disease diagnoses for syncope
- Educate medical staff on conditions and factors that warrant inpatient admission
- Review orders sets and make changes as needed

CMS Demonstrations

On January 1, 2012, CMS postponed the start of the prepayment review demonstration and prior authorization of power mobility devices demonstration. Once again, there will be critical processes to put in place. The delay will allow providers time to implement processes to address these demonstration projects smoothly. The program now will start after June 1, 2012.

Organizations should use this time to work with the coding department, case management, and patient financial services to determine their approach; for example, whether they will perform prebill coding validation as well as QA on order status and medical necessity.

Providers continue to have a great deal to think through, reassess, and reorganize, as this is only the beginning of what is to come in the world of audits.

Notes

1. Centers for Medicare and Medicaid Services. "Current Programs." www.cms.gov/Recovery-Audit-Program/03_Current_Programs.asp.
2. Centers for Medicare and Medicaid Services. "Medicare Fee-For-Service 2010 Improper Payment Report." www.cms.gov/CERT/Downloads/Medicare_FFS_2010_CERT_Report.pdf.
3. Centers for Medicare and Medicaid Services. "RAC Statement of Work." September 1, 2010. www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf.
4. American Hospital Association. AHA RACTrac 3rd Quarter 2011 Report. www.aha.org/content/11/11Q3rac. tracresults.pdf.

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