Preparing for RAC Prepayment Reviews

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by Sharon Easterling and Donna D. Wilson

We are now midway through 2012, and still awaiting the start of RAC prepayment reviews. The program was originally scheduled to start shortly after January 1, 2012, but has been pushed back until sometime during the summer of 2012. In the meantime, we are in the midst of struggling to meet the demands of RAC post-payment reviews, and trying to stay afloat with the present audit climate in general. And CMS has made it clear the RAC prepayment reviews will not replace any other ongoing review activities and that the MAC will continue to perform prepayment reviews on other target areas.

CMS has stated that this demonstration will allow the evaluation of, "whether Recovery Auditors can have an impact on the amount of improper payments that can be prevented through prepayment review without requiring additional MIP funding. The demonstration would also evaluate if the increased amount of prepayment review can have a significant impact on lowering the error rate and lowering the risk of fraudulent occurrences." CMS established a goal of $50 billion for the RAC prepayment review program, but has initially identified only eleven states for the demonstration project, eleven HEAT states (CA,FL,IL, LA, MI, MY and TX), and four states with high volumes of short-stay cases (MO, NC, OH, and PA). CMS has estimated that 115,000 claims will be reviewed per year during the demonstration period.

Coding/Medical Necessity Targets

Utilizing short stay (two days or less) DRG analytics, CMS identified claims with disproportionately high rates of improper payment. The first group of DRGs that will be subject to prepayment review include the following:

- MS-DRG 312, syncope and collapse
- MS-DRG 069, transient ischemia (TIA)
- MS-DRG 377, gastrointestinal (GI) hemorrhage with MCC
- MS-DRG 378, gastrointestinal (GI) hemorrhage with CC
- MS-DRG 379, gastrointestinal (GI) hemorrhage without a CC or MCC
- MS-DRG 637, diabetes with MCC
- MS-DRG 638, diabetes with CC
- MS-DRG 639, diabetes without a CC or MCC

Proactive Approach

Inpatient coders should be cognizant of the RAC prepayment MS-DRGs, and ensure that the correct code and corresponding MS-DRG are assigned. Coders and coding managers may want to consider a second level review of these cases to verify the code assignments and sequencing. Oftentimes, these short-stay admissions can be a coding challenge, given the limited documentation in the medical record, although the physician should be queried when clarification is needed.

Case managers should also be made aware of these targeted DRGs to ensure the appropriate level of care, and should also consider performing confirmatory pre-billing reviews to avoid patient status billing errors. Since most case management departments do not have 24/7 coverage, any short-stay admissions that fall on weekends and nights should be reviewed in a timely manner.

As CMS expands their targeted Prepayment Review MS-DRG listing, surgical procedures may be added, which will require a focus on elective surgical procedures that are not on the Medicare inpatient only listing and could have been performed on an outpatient basis.

As is the case with all CMS review initiatives, physicians, coders and case managers should be reminded of the importance of accurate and complete documentation to support the medical necessity of the hospital inpatient admission, as well as the

correct coding/DRG assignment.

Current Focus

Whether prepayment reviews are being performed by the RAC or MAC, providers should be proactively preparing themselves concurrently. The MACs are capable of employing prepayment edits that hold claims once they are billed. These edits are based off of beneficiary's Health Insurance Claim Number (HICN), a provider's identification number (PIN/UPIN) or National Provider Identifier (NPI) and specialty code, service dates, and diagnosis or procedure code(s) (i.e., Healthcare Common Procedure Coding System [HCPCS] and/or International Classification of Diseases [ICD]-9 diagnoses codes), Type of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes. Once these key components are put into play comparisons can be made on items such as type of bill, length of stay and DRG for the RAC prepayment reviews. Once the claim has been targeted the provider will have 30 days to submit all requested documentation. Providers may ask for an extension however if no documentation is received by day 45, a denial may be issued. A recent update (June 2012) in PIM Chapter 3 states… "*The MACs, CERT, and Recovery Auditors, shall request records related to the claim(s) being reviewed and have the discretion to collect documentation related to the beneficiary's condition before and after a service*." Be mindful of these and all documentation requested when the ADR is received.

References

Centers for Medicare and Medicaid Services. "CMS Recovery Auditor Prepayment Review Demonstration" January 2012. https://www.cms.gov/CERT/downloads/RAC_Prepay_slides.pdf.

Centers for Medicare and Medicaid Services. Recovery Audit Program Overview Web Page. https://www.cms.gov/Recovery-Audit-Program/.

Centers for Medicare and Medicaid Services. "Medicare Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration." CMS 10421. https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/Downloads/CMS-10421.pdf.

Centers for Medicare and Medicaid Services. "Chapter 3 – Verifying Potential Errors and Taking Corrective Actions." *Program Integrity Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf.

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