RAC Review — Lessons Learned from Rehabilitation Providers

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Background

- Medicare Prescription Drug, Improvement and Modernization Act of 2003
  - Mandated Recovery Audit Contractor (RAC) Demonstration project initiated in 2005 in three states (CA, NY, FL)
- Tax Relief and Health Care Act of 2006
  - Established permanent program and expanded to all states by 2010

Lessons Learned

- Challenge inappropriate denials
- Communicate and collaborate
  - With peers
  - With state association
- Understand the RAC program
- Understand applicable regulations
- Make necessary operational changes
Demonstration Program

• Goal: to determine whether the use of RACs is a cost-effective means of:
  o Identifying underpayments and overpayments
  o Recouping overpayments

• Contractor paid on a contingency basis
  o In Demo, RAC retained fee if denial passed first appeal level with fiscal intermediary

RAC Reviews

Two types of review:

1. Automatic review — Computerized analysis of claims and coding patterns; for example, coding errors

2. Complex medical review — The human review of a medical record or other documentation; for example, medical necessity of admission to inpatient care
RAC Review Process

• RAC requests medical record for review, and provider submits within 45 days

• If not received, RAC must make second request; if still not received, may determine that the claim was improperly paid

• The RAC must render a determination within 60 days of receipt of the record

RAC Review Process (cont.)

• When an overpayment determination is finalized, the RAC will issue a demand letter to the provider, including:
  o Denial amount and method of calculation
  o Rebuttal and appeal rights
  o Recoupment, payment and interest options and related timelines

• Remittance advice will indicate a pending recoupment with RAC remark code “N432”
During the demonstration, admissions to inpatient rehabilitation facilities (IRFs) were the subject of extensive review; results revealed significant problems with the RAC Program and its effect upon providers of all types.

- High rates of “overpayment determinations”
- Confusing, inconsistent communication
- Unqualified review personnel
- Determinations inconsistent with Medicare Policy
- Reasons for determination not clear
- Immediate recoupment of reimbursement
- Significant time and resources needed to pursue appeals
RAC Demonstration Program (cont.)

• In response to the high number of inappropriate denials, California IRFs filed appeals to the fiscal intermediary
  • Most appeals were upheld at the initial levels of appeal
    o Redetermination
    o Reconsideration
  • The vast majority of appealed IRF cases (> 90%) were overturned at the Administrative Law Judge (ALJ) level

RAC Demonstration Program (cont.)

• Throughout the demonstration program, IRFs stayed in close communication with each other and with the state association
  o Shared experiences and strategies for response
  o Supported CHA’s advocacy to CMS and
  o Supported CHA’s Congressional advocacy
RAC Demonstration Program (cont.)

- In response to CHA IRF advocacy, CMS
  - “Paused” all IRF reviews
  - Conducted Validation Review
    - Discontinued all further IRF review
    - Ordered re-review of all previous unfavorable determinations, and refund recouped reimbursement as indicated

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The “New and Improved” RAC Program

• In response to the concerns of providers and problems encountered during the demonstration, CMS made several important changes in the permanent program

Customer Service

RACs are required to:

• Establish a toll-free customer service phone line
• Have a knowledgeable customer services staff
• Implement a quality assurance program
• Meet specific standards for communication
• Provide education regarding RAC
• Maintain a webpage
The “New and Improved” RAC Program (cont.)

**Issue Review Board**

- CMS established an “issue review board” that
  - Approves review issues proposed by the RAC
  - Approves review methodology
- Approved issues must be posted to the RAC website in advance of review activity

The “New and Improved” RAC Program (cont.)

**Record Request Limits**

- Maximum number of requests in 45 days is 400 (600 for providers with > $100,000,000 in MS-DRG) *per campus*
- RAC may select up to 70% of any specific claim type for review
- CMS may give the RAC permission to exceed the limit
Personnel Qualifications

• RACs must employ at least one full-time medical director with relevant work and education experience
• Determinations must be made by registered nurses or therapists, or certified coders; a provider may request information about the credentials of the reviewers

Review Policies

• Determinations must be based on all national coverage determinations, coverage provisions in interpretative manuals, national coverage and coding articles and local coverage determinations
• The RAC shall not make denials on minor omissions (e.g., missing dates) if documentation indicates other coverage/medical necessity criteria are met
The “New and Improved” RAC Program (cont.)

**Contingency Fee**
- If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider’s favor at **ANY** level, the RAC shall repay Medicare the contingency payment for that recovery.

The “New and Improved” RAC Program (cont.)

**Recoupment Process**
- CMS will not begin recoupment when it receives notice that the provider has filed for redetermination or reconsideration (first or second level of appeal), *within 30 days* of the demand letter.
- If the denial is upheld, CMS will initiate recoupment with interest; if the denial is reversed at the ALJ level, CMS will refund any collected reimbursement with interest.
The “New and Improved” RAC Program (cont.)

Discussion Period
Following an unfavorable determination, the RAC must offer a “discussion period”
- May be requested via information provided in the determination letter or at the website
- The 41-day discussion period begins effective the date of the demand letter; request for discussion does not affect timelines for appeal

“Doc-to-Doc Review”
“If the provider requests to speak to the corporate medical director (CMD) regarding a claim(s) denial, the RAC shall ensure the CMD participates in the discussion”*
- Request through customer service
- Document requests
- Prepare cases for review
- Involve treating physician

*CMS Statement of Work for the Recovery Audit Program, page 23
The “New and Improved” IRF

- The RAC demonstration revealed the need to update and clarify IRF medical necessity criteria and associated policies and requirements
- CMS initiated a review and revision of IRF policy, and initiated extensive provider education
- CHA provided input to the changes and coordinated communication with member facilities

In response to the RAC experience and changes the Medicare policy, IRF implemented operational changes
- Inter- and intra-departmental communication
- Documentation procedures
- Admission criteria
- Tracking and appeals process
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Communication

Establish timely interdepartmental communication
• Notify clinical and reimbursement staff of medical record requests
• Notify clinical and reimbursement staff of RAC determinations
• Monitor remittances for reimbursement adjustment and communicate to clinical personnel
• Review clinical charts prior to submission
Record Keeping

Maintain records of RAC review requests and results

- Number of claims requested
- Results/number of denied claims
- Date of reimbursement recoupment
- Amount of reimbursement recovered
- Maintain records of all communication
- Appeal status and timelines

Discussion, CMD Review and Appeals

Carefully consider value/needs

- Cost effectiveness (resource use)
- Quality of charts and documentation
- Implications of challenging/not challenging claim denials
- Seek clinical input
- Seek legal counsel
- Use the Discussion Period!
- Use the CMD Review!
Discussion, CMD Review and Appeals

Providers will benefit from developing comprehensive appeal process
  • Maintain good calendaring system
  • Keep copies of all filings
  • Clinical arguments should be specific to individual patient
  • Refer to specific portions of the medical record

2013 IRF RAC Reviews

  • In the spring of 2013, IRF members reported receiving a high volume of requests for IRF records
  • Initial review results indicated a high rate of unfavorable determinations
  • The volume of requests quickly escalated
2013 IRF RAC Reviews (cont.)

- CHA member IRFs worked together to share information, communicate with HDI and challenge inappropriate denials
- CHA initiated communication with HDI as needed
- IRFs proceeded with doc-to-doc reviews requests on most denied cases

2013 IRF RAC Reviews (cont.)

- HDI discontinued reviews in process and closed associated claims
- HDI canceled pending record requests and closed associated claims
- Member IRFs report 50% - 100% of cases reviewed via for “doc-to-doc” review were overturned
Advocacy

Support H.R. 1250 and S. 1012

*The Medicare Audit Improvement Act of 2013*

Resources

CMS Website:

HDI Website:
https://racinfo.healthdatainsights.com/home.aspx?
ReturnUrl=%2f
Summary

- The practices of the Recovery Audit Contractor program presents significant challenges to providers and to patient access.
- Providers at all levels of the continuum of care must work together to ensure compliance with Medicare policies and to preserve the ability to provide appropriate patient care.

QUESTIONS?
Thank you

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