

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

Q. Can you give any advice on how to defend a social admission (need the 3 day qualifying stay before Medicare covered SNF stay) if they do not meet InterQual criteria?

- A. So-called "social admissions" just to meet the three-day SNF requirements is a RAC target issue. Admissions must be documented to be medically necessary to be covered by Medicare. That being said, it is helpful to keep in mind that InterQual criteria is a guideline and a case finding tool to be used primarily by non-physician reviewers. Physicians' independent medical judgment is taken into consideration when determining medical necessity for admission.

Q. Can records be submitted as scanned records on CDs?

- A. Yes. CMS requires that RACs develop the ability to accept imaged medical records sent on compact disk or digital video device. In 2010 this will be done via the 277 Transaction Record (RACs must remain capable of accepting faxed or paper medical records indefinitely). Note: Providers and their clearinghouses will first need to successfully complete a connectivity and readability test with the RAC system before being able to submit imaged or electronic records to a RAC. RACs are also permitted to obtain copies of medical records by going on-site to the location to view/copy the records or by requesting that the provider mail/fax or otherwise securely transmit the records to the RAC. (Marsh risk reduction note: faxing is not recommended due to potential for misdirection).

Resources:

www.cms.hhs.gov/OpenDoorForums/downloads/bulkfilepartarac111208.pdf
www.aha.org/aha/content/2008/pdf/0801125-racfaq.pdf
www.cms.hhs.gov/RAC

Q. Can you describe/clarify the various audit categories and appeal levels.

- A. The RAC appeals process mirrors the five-levels of Medicare appeals through which all fee-for-service providers appeal reimbursement decisions. A CMS summary of the process is available at:
<http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>

The process is summarized as follows:

1. Redetermination by the Fiscal Intermediary. First level appeals, referred to as redeterminations, are made to a provider's Medicare Fiscal Intermediary ("FI") or Carrier and must be filed within 120 days of receipt of the demand letter. No monetary threshold is applied to first level appeals.
2. Reconsideration by a Qualified Independent Contractor. Second level appeals, referred to as reconsiderations, are made to a Qualified Independent Contractor and must be filed within 180 days of receipt of the redetermination. No monetary threshold is applied to second level appeals.

Legal Disclaimer: The information contained in this FAQs document is intended to provide information of general interest to the public and is not intended to offer legal advice about specific situations or problems. No responsibility is assumed by McGuireWoods LLP for the accuracy or timeliness of any information provided in this document. This document does not intend to, and does not, create an attorney-client relationship with McGuireWoods LLP by offering this information, and anyone's review of the information shall not be deemed to create such a relationship. The impact of the law for any particular situation depends on a variety of factors. You should consult professional counsel if you have legal matters requiring legal attention.

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

3. **Administrative Law Judge Hearing.** Third level appeals, a hearing before an administrative law judge (“ALJ Hearing”), are available if the amount in controversy totals at least \$120. A request for an ALJ Hearing must be filed within 60 days of receipt of the QIC reconsideration decision.
4. **Medicare Appeals Council Review.** Fourth level appeals are made to the Medicare Appeals Council (“MAC”) and must be filed within 60 days of receipt of the ALJ Hearing decision.
5. **Judicial Review in U.S. District Court.** Judicial review in U.S. District Court is only available if the amount remaining in controversy totals at least \$1,220. The request for judicial review must be filed within 60 days of receipt of the MAC decision.

Q. If we automatically refund instead of spending the money and time to appeal, will that create any possible future red flags?

- A. The legally allowable recoupment options given to providers include the choice to: allow recoupment, pay by check, stop recoupment by filing an appeal, or sign up for an extended repayment plan. There was no CMS commentary found raising any red flags if an organization chose any particular legal option available for recoupment.

Q. What is the actual interest rate?

- A. The interest rate in effect on the date of final determination is the rate that will apply for the entire life of the overpayment. Example, if the average overpayment for 100 claims is \$50 per claim, and claims were submitted for 20,000 Medicare patients during the time frame, the overpayment amount due to Medicare within 30 days of the notice is calculated at \$50 x 20,000, or \$1,000,000 with a current interest rate of 11.125 percent on any unpaid balance calculated from the 31st day after notification. C.F.R. § 405.378). The interest rate is the higher of the current value of the funds rate or the private consumer rate, as fixed by the Department of Treasury. Per information published at the most recent National Medicare RAC Summit, the interest rate is based on the most recent quarterly Treasury Consumer Market Rate.

Adjustment of Interest Charges Reopenings-FI

When the FI reopens a final settlement pursuant to 42 CFR 405.1885 - 1887(a) and such reopening reverses some or all adjustments, whereby the previous overpayment is reduced or eliminated, it makes an appropriate adjustment to previously assessed and recovered interest to reflect the proper interest chargeable under 42 CFR 405.378 and the policies set forth.

Should the reopening action establish or increase an overpayment, the rate of interest on the additional or new overpayment is the rate in effect as of the date of the new notice of final determination.

Legal Disclaimer: The information contained in this FAQs document is intended to provide information of general interest to the public and is not intended to offer legal advice about specific situations or problems. No responsibility is assumed by McGuireWoods LLP for the accuracy or timeliness of any information provided in this document. This document does not intend to, and does not, create an attorney-client relationship with McGuireWoods LLP by offering this information, and anyone’s review of the information shall not be deemed to create such a relationship. The impact of the law for any particular situation depends on a variety of factors. You should consult professional counsel if you have legal matters requiring legal attention.

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

If the original cost report was not submitted timely, any reopening action, which results in an adjustment to the previously determined overpayment, shall also include an appropriate adjustment to the late filing interest assessment.

FI and Provider Reimbursement Review Board Hearings - Institutional Providers Serviced by FIs

If an overpayment or underpayment determination is reversed administratively by the FI or by the PRRB, and the reversal is the final decision in the case, it is necessary to recalculate the correct amount of interest to be assessed. If any excess interest or principal has been collected, the FI refunds it to the debtor. No interest accrues on the refunded amount unless payment is not made within 30 days from the date of notification of the corrected overpayment or underpayment amount.

If the hearing results in an additional overpayment, the FI assesses interest on the additional amount at the rate in effect on the date of the revised final determination. **Interest does not accrue until the FI notifies the provider of the revised overpayment or underpayment amount.**

Example of Application

On 07/18/05, the intermediary completes a final settlement and issues a NPR and a written demand showing an amount due the program of \$16,000. On 09/15/05, the provider pays the \$16,000 overpayment plus one 30-day period of accrued interest. As a result of a hearing on 12/10/05, the PRRB reverses the intermediary's findings and determines that the correct amount due the program was \$4,000. The excess \$12,000 in principal and the accrued interest on \$12,000 that was assessed and collected must be returned to the provider.

Judicial Review

The policies and procedures of this section do not apply to the time period for which interest is payable under 42 CFR 413.64(j) because the provider seeks judicial review of an adverse decision by the PRRB or the decision of the Administrator. Section 1878(f) of the Social Security Act authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. The interest is payable for the period beginning on the first day of the first month following the 180-day period which began on either the date the intermediary made a final determination or the date the intermediary would have made a final determination had it been done on a timely basis. The interest rate assessed is the rate on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. This rate of interest can be found at <http://cms.hhs.gov/statistics/trust-fund-interest-rates/>. If the FI withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider. However, if the Medicare program had recovered any of the amount in controversy interest would be payable from the time of recovery through the date of payment.)

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

- Q. What criterion are RACs applying to determine medical necessity on admissions-specific to LTACHs. Our QIO in MA used NALTH criteria from 10/06 onward. Will RACs take this into consideration or will they strictly apply InterQual?**
- A. RACs are not bound to use InterQual or any particular screening criteria, CMS left it up to each individual RAC to determine which criteria it will use. NCD, LCD and CMS manual compliance is required. When there is a complex review for which no written Medicare policy, articles, or coding guidelines exist, it is considered an individual claims determination. In these situations RACs are to use appropriate medical literature and apply appropriate clinical judgment.

It is worth noting, however, that CMS recently awarded a contract to Wisconsin Physician Services (WPS) (not a RAC) to review LTACH Medicare claims for discharges occurring on or after October 1, 2007 to determine whether LTACHs are admitting only medically appropriate patients. WPS began conducting these reviews in January 2009. In a recent telephone conversation with a representative from WPS, we were informed that WPS would use both InterQual and other selected criteria to evaluate medical appropriateness of admission in an LTACH setting and to recoup overpayments. Some LTACHs have already reported that WPS has used minor coding deficiencies to deny claims for patients with lengths of stay in excess of 70 days. Information collected from WPS under this contract will be used by CMS to develop a national error rate for medically unnecessary patient admissions to LTACHs, *and may be shared with recovery audit contractors (for purposes of adding this data to the RAC data warehouse), fiscal intermediaries and quality improvement organizations.*

- Q. From a hospital based physician standpoint, specifically emergency medicine, it would seem that the risk of a RAC audit is low. This is because it was stated that simply E & M coding error would not be allowed in an audit. Do you agree with this statement?**
- A. A review of Evaluation and Management codes was not included in the demonstration project but will be in the permanent RAC program. If the number of your higher E/M levels exceeds that of other emergency physicians in your state, you should perform an audit to ensure that documentation will support the levels billed to take a proactive stance. This should be a routine practice. If the ED utilizes a separate documentation template it must be provided with the medical record that the hospital submits to the RAC. If not, EM physicians can be liable for repayment of the entire amount Medicare paid to the EM for the claim. If the ED record is illegible (common problem with non-EMR ED records) or due to poor copy quality, an overpayment liability could be found by default.

See also: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=7738&p_created=1153331787&p_sid=_qdee2qj&p_accessibility=0&p_redirect=&p_lva=&p_sp=cF9zcmNoPSZwX3NvcnRfYnk9JnBfZ3JpZHNvcnQ9JnBfcm93X2NudD0yNiwyNiZwX3Byb2RzPSZwX2Nhdm9JnBfcHY9NC40OTcmcF9jdj0mcF9zZWfyY2hfdHlwZT1hbnN3ZXJzLnNiYXJjaF9ubCZwX3BhZ2U9MQ**&p_li=&p_topview=1

Legal Disclaimer: The information contained in this FAQs document is intended to provide information of general interest to the public and is not intended to offer legal advice about specific situations or problems. No responsibility is assumed by McGuireWoods LLP for the accuracy or timeliness of any information provided in this document. This document does not intend to, and does not, create an attorney-client relationship with McGuireWoods LLP by offering this information, and anyone's review of the information shall not be deemed to create such a relationship. The impact of the law for any particular situation depends on a variety of factors. You should consult professional counsel if you have legal matters requiring legal attention.

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

Q. Do you provide educational training geared to physicians for both hospital and office documentation and hospital admission guidelines?

A. Yes, Marsh provides physician education regarding RAC readiness.

Q. Are there any clients or list serves out there that people that have been through RAC who are willing to share information?

A. We generally cannot recommend any informal list serves because we would not be able to ensure the accuracy of information shared. Instead, we recommend a review of the transcript of the November 12 & 13, 2008 Open Door Forums by CMS in which clients expressed some of their experiences. A copy of the transcripts is available at:

<http://www.cms.hhs.gov/OpenDoorForums/downloads/bulkfilepartarac111208.pdf>;

<http://www.cms.hhs.gov/OpenDoorForums/downloads/bulkfilepartbrac111308.pdf>.

We also recommend reviewing the CMS report The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, June 2008, available at: <http://www.cms.hhs.gov/RAC/>

Q. What's the likelihood for ancillary providers to become the subject of a RAC audit or is most of the focus on hospitals?

A. Anyone who submits a Medicare Part A or Part B claim may be subject to a RAC audit. If by ancillary providers the question is referencing other Medicare Part B billers (DME, Ambulance, Lab) by National Provider Number, the answer is yes, they can be subject to a RAC audit. To our knowledge, RACs do not intend to focus their audit efforts on a particular type of provider.

Q. If we self report and refund based on self audit, but it's done via extrapolation, how does the RAC exclude these cases?

A. If a provider voluntarily self-reports, a RAC is required to cease all recovery efforts for the claims involved immediately upon becoming aware of the self-reporting through notification from the provider or a Medicare contractor. If the self-report from the provider does not involve the same types of services for which the RAC issued a demand letter or a request for medical records, the RAC may continue recovery efforts. As a point of information regarding extrapolation, the demonstration RACs did not use extrapolation (although that methodology was available). The permanent RACs can use extrapolation if they choose, and must abide by all of the same requirements currently in the program integrity manual regarding extrapolation.

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

Q. You didn't address the process for receiving underpayments. Aren't the RAC auditors required to report underpayments, as well as overpayments?

- A. Yes, RACs are required to report both over and underpayments. Upon identification, the RAC will communicate the underpayment finding to the appropriate FI, carrier or other contractor. The contractor will validate the underpayment, adjust the claim, and pay the provider. The RAC will issue a written Underpayment Notification Letter to the provider outlining the claim and beneficiary detail. Neither the RAC nor the AC may ask the provider to correct and resubmit the claim.

For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group would create an underpayment, the RAC will identify an underpayment. Service lines or payment groups that a provider failed to include on a claim are **NOT** considered underpayments for the purposes of the program. A RAC is not required to accept unsolicited case files from providers for an underpayment case review. However, RACs may request medical records for the sole purpose of identifying an underpayment review. The same requirements to pay for copies of requested medical records apply to RACs regardless of whether an underpayment or overpayment is determined.

Q. How will the RAC obtain the appropriate contact person at the facility level?

- A. According to the CMS November 2008 Open Door discussion, it is the responsibility of the *provider* to notify its RAC regarding the facility contact person.

Q. From a hospital based physician standpoint, specifically emergency medicine, it would seem that the risk of a RAC audit is low. This is because it was stated that simply E & M coding error would not be allowed in an audit. Do you agree with this statement?

- A. These audits can occur in the permanent RAC program. See: www.CMS.HHS.gov/rac

Q. If condition 44 is used too often or never used, does that set off a red flag to CMS?

- A. We have no indication that the frequency of use of condition code 44 has set off red flags at CMS. However, if you are regularly using this process to correct admission status orders, we recommend you take a close look at your gate-keeping and pre-admission screening processes. You may also consider the CMAP (case management admission protocol) which would significantly reduce these retro-fixes.

RECOVERY AUDIT CONTRACTORS (RAC) FREQUENTLY ASKED QUESTIONS

Q. Can queries be used retrospectively to address level of care (LOC) orders?

- a. If there is no order for LOC?**
- b. If there is conflicting or unclear orders in the chart?**
- c. If there is an incorrect order?**

A. It is recommended that the physician writes an order clarification to address a previously written unclear order or to clarify conflicting LOC orders. Most QIOs have historically interpreted the term “admit” as an order for inpatient admission in the absence of other clarification. This becomes problematic when pre-printed orders contain check boxes for both inpatient and observation statuses, both are left blank and the physician writes, “admit for observation”. In this case, a clarification order is needed. Otherwise, the issue is left open to interpretation by the reviewing entity.

Q. New York State’s QIO (IPRO) utilizes Milliman for medical necessity but we utilize InterQual, how would you argue?

A. No particular criteria are required. Ultimately, the record must reflect medical necessity and appropriateness of admission and care. Although QIOs are no longer administering the hospital payment monitoring program (HPMP), you may find that RACs and other entities use a combination of various criteria sets.

Q. If defending an appeal, what would take precedence: internal policies approved by the MEC and legal counsel or State / Federal Regulations?

A. Compliance with state and federal regulations is required and would take precedence. Internal policies and procedures must be consistent with Federal and state law and regulations.

Q. If a patient does not meet observation criteria should an ABN be issued?

A. ABNs are issued prior to an OP service that may not meet medical necessity criteria. If a physician orders outpatient observation for a patient for a patient not documented to meet observation criteria, we recommend notifying the physician of the need for additional documentation or an alternative level of care. This usually leads to a resolution.