American Hospital Association

RAC REPORT

Recovery Audit Contractor Program Update

October 5, 2009

In recent meetings with AHA, the Centers for Medicare & Medicaid Services (CMS) provided the following updates on the Medicare Recovery Audit Contractor (RAC) Program. In addition, we highlight other recent RAC news and resources.

RAC Roll-out

As of September 18, all four RACs are actively conducting automated audits that include outpatient hospital, physician and durable medical equipment claims. RACs are eligible to conduct only those audits approved through CMS' "new issue review" process. For details on particular audits, visit the individual RAC's Web-pages using the links below:

RAC	Website	No. of Total Active Audits	No. of Hospital Outpatient Audits
RAC A – DCS	http://www.dcsrac.com/portal.html	3	0
RAC B – CGI	http://racb.cgi.com/	3	3
RAC C – Connolly	http://www.connollyhealthcare.com/RAC	10	6
RAC D – HDI	https://racinfo.healthdatainsights.com/	7	7

RAC Outreach Schedule

As of 09/18/09

A
B
C
D

Completed
October

RAC audits may begin in all states once CMS and the RAC have conducted provider outreach (see CMS' map above) and the RAC has entered into a joint operating agreement with the Medicare claims processing contractors (Medicare administrative contractors (MAC), fiscal intermediaries (FI), carriers, and other contractors).

Audit Types

CMS reports that, to date, more than 100 audit requests have been submitted to CMS for new issue review. While these include some DRG and code validation reviews, which would involve RAC review of hospital medical records, these particular types of audits have not been approved by CMS. Instead, for now, CMS has approved only automated audits, which rely on software analysis to find technical errors such as coding errors.

CMS has delayed approval of complex audits, including medical necessity reviews, in order to finalize processes and policies related to requesting and auditing medical records. DRG and coding validations are likely to begin in November 2009 at the earliest, with medical necessity reviews delayed until calendar year 2010.

CMS also announced that it *may* delay a particular type of medical necessity review, short-stay inpatient claims determined by a RAC to be suitable outpatient claims, until CMS can establish a process through rulemaking to allow for rebilling all eligible outpatient claims. It is possible that such a proposal may be addressed by CMS through rulemaking in the future.

Medical Record Request Limits

CMS announced that it plans to replace the current draft policy on medical record request limits, which bases per organization limits on national provider identifier (NPI) numbers, with a policy that will establish a limit based on organizational tax identification numbers. This will address the complication associated with setting limits for organizations with multiple NPIs. Details on the new policy are pending and we will inform the field as we learn more.

Commercial Screening Tools

The vendors for the commercial screening tools Interqual and Milliman have both provided their tools to the RACs at no cost. The RACs indicate that they may try to use both tools by matching a particular tool used for a RAC audit to the tool used by the corresponding FI, MAC or other claims processing contractor that processed the claim.

CMS Announces Town Hall Meeting on 935 Appeals Process

CMS has provided early notice of an upcoming "town hall meeting" conference call on Section 935 appeals on Thursday, November 5, from 1-3:30pm ET. To pre-register for this call, email medicareoverpayments@cms.hhs.gov. CMS will issue additional details, including an official meeting notice, in the coming weeks.

Background on Section 935 Appeals. Section 935 of the *Medicare Modernization Act of 2003* established a new option for providers appealing a Medicare denial. Under the 935 process, providers may submit certain appeals within condensed timeframes to delay recoupment. To qualify, a Level 1 appeal must be filed within 30 days of the date of the

demand letter; a Level 2 appeal must be filed within 60 days. By meeting these early deadlines, recoupment will be postponed until stage three of the appeals process or until the appeal is won by the provider, whichever occurs first. The Medicare appeals process is described in further detail in AHA's March 2009 advisory available at www.aha.org/rac, and in CMS Transmittal 141.

Remittance Advice Update
According to CMS, listings of RAC-related claims activity on the Medicare remittance advice will be marked with code N432. CMS further notes that the RAC code will be used in conjunction with other codes to provide additional detail on a claim – for instance, code N469 may also be used to indicate that recoupment should be delayed under the Section 935 appeals process described above.

CMS is aware of several problems with the current process that prevent claim-level reconciliation by hospitals. Specifically, while the remittance advice uses codes to notify hospitals that a RAC or other CMS contractor identified a particular claim for future recoupment, the remittance advice fails to provide claim-specific data when the recoupment is processed. Instead of *claims-level detail*, the remittance advice *combines* information on all recoupments occurring on a particular day into a single batched amount. The lack of claim-level data on the remittance advice at the point of recoupment prevents hospitals from reconciling anticipated recoupments with actual recoupments.

CMS is developing a solution to this problem, with implementation targeted for summer 2010; this would be announced to its contractors in a transmittal and to providers in a MedLearn Matters Article. AHA is working with CMS and several state hospital associations on this problem.

RAC Use of Local Coverage Determinations
On September 25 CMS issued Transmittal 303, which enables the contract medical director of RACs and other CMS contractors to waive the clinical criteria found in local coverage determinations (LCD) when conducting complex reviews of Medicare claims. Such LCD waivers are to be used on an individual claim and "rare and exceptional" basis. CMS states that its intention behind Transmittal 303 is to grant its contractors flexibility when assessing the clinical merits of a claim that may not technically comply with LCD criteria, but due to unique circumstances should be covered by Medicare.

RACTrac Update
RACTrac Data Collection to Begin January 2010. RACTrac, a Web-based survey to track the impact of RAC activity on hospitals, will begin quarterly data collection in early January. RACTrac is designed to provide ongoing monitoring to ensure RAC adherence to Medicare policy, assess RAC implications for broader policy issues such as medical necessity, and measure the true impact of the RAC program on the provider community and the Medicare program as a whole. The initial launch will focus on states that have had significant RAC activity by the end of the fourth calendar quarter of 2009.

Six Vendors Named "RACTrac Compatible". Six vendors of RAC activity management tools have been named by AHA as "RACTrac Compatible." This designation means that

these vendors have created a mechanism in their tool to quickly and easily summarize data for upload or entry into RACTrac, **and** that this mechanism has been tested and validated by the AHA. The AHA also continues to work with other vendors of RAC audit tracking tools to ensure their products are "RACTrac compatible."

Free Claim-level Tracking Tool Available. The AHA has made available to all hospitals a free claim-level Excel tool to assist in tracking RAC audits. This tool also quickly and easily summarizes data for upload into RACTrac.

The list of RACTrac Compatible Vendors, the claim level tool and other information on the RACTrac initiative can be found at www.aha.org/rac under "RACTrac."

Further Questions

For more information on the RAC program, visit www.aha.org/rac. If you have further questions, please e-mail Rochelle Archuleta at rarchuleta@aha.org or the AHA RAC information line at racinfo@aha.org.