Presentation to the Iowa Hospital Association Annual Meeting

The CMS Recovery Audit Contractor (RAC) New York Experience

October 7, 2009

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The RAC Program

- Background
- The RAC Mission
  - Demonstration
  - National Expansion
- What does the RAC do?
- What happened in New York?
- What you can do to prepare for RACs…

Not to be confused with

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Background

- RACs were created by the Medicare Modernization Act, Section 306, which required a three year RAC demonstration in the states with the highest volume of Medicare claims
- The Tax Relief and Healthcare Act of 2006, Section 302, made the RACs permanent and required the program to be nationwide by the end of 2010
- Both Statutes gave CMS the authority to pay the RACs on a contingency fee basis.

The RAC Program Mission

- The RACs detect and correct past improper payments so that CMS, Carriers, FIs, and MACs can implement actions that will prevent future improper payments
- Providers can avoid submitting claims that do not comply with Medicare rules
- CMS can lower its error rate
- Taxpayers and future Medicare beneficiaries are protected

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Results of the Demonstration Program

- CMS produced an Evaluation Report in June 2008
  http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf
- RACs identified more than $1 Billion in improper payments, mostly overpayments
- CMS says RACs are good: *"The RAC demonstration... successful in returning dollars to the Medicare Trust Funds... provided CMS with a new mechanism for detecting improper payments... a valuable new tool for preventing overpayments in the future"*

What were the results of the demo?

- Nationally, $1.03 Billion improper payments identified
  - 96% was for overpayments
- Hospitals accounted for 89% of overpayments

What were the results of the demo?

Overpayments by type of error

- 40% Medically Unnecessary
- 35% Incorrectly Coded
- 8% Insufficient/No Documentation
- 17% Other

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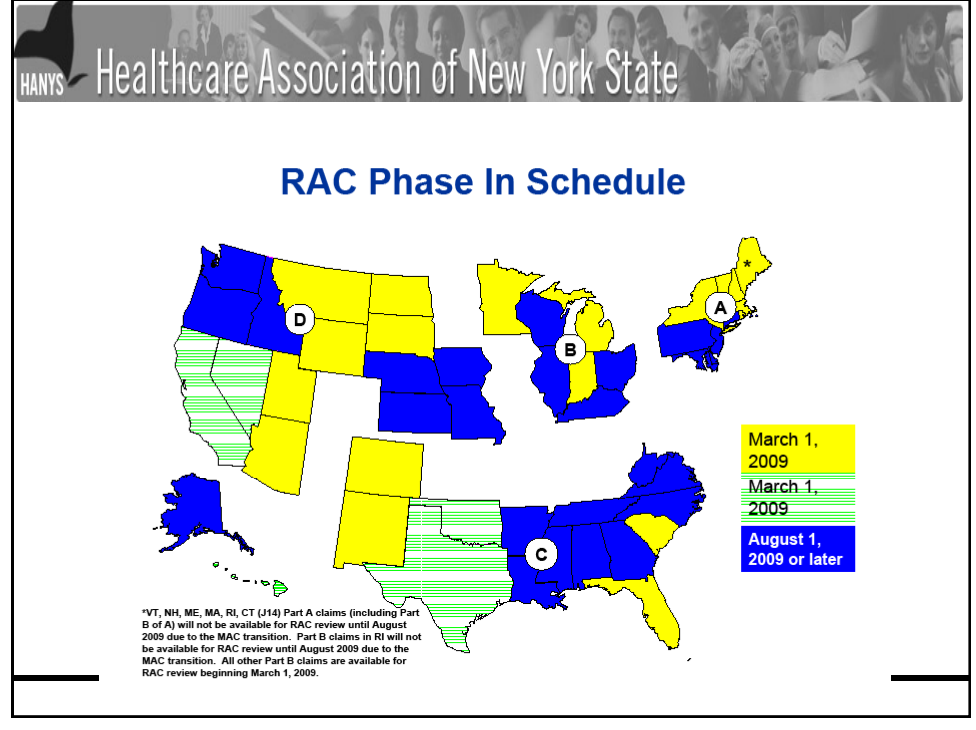
4 Contractors selected for the National Expansion:

- Region A: Diversified Collection Services (DCS)
- Region B: CGI Technologies and Solutions, Inc.
- Region C: Connolly Consulting, Inc.,
- Region D: HealthDataInsights (HDI), Inc., of Las Vegas, NV - Iowa RAC



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What claims can the RAC target?

- **Providers who submit fee-for–service claims to Medicare are potentially targets for review**
- **The RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.**
  - **LCD**
  - **NCD**
  - **Interqual and Milliman criteria**

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With all these audits going on, will the RAC target the same claims already being audited?

- **CMS created a RAC data warehouse to track information about claims reviewed by the RACs.**
- **Other Medicare contractors use this data warehouse to designate which claims had been previously reviewed and were therefore excluded from review by the RACs.**

What does and doesn't the RAC do?

- RACs cannot review claims paid before October 1, 2007
- RACs cannot look more than 3 years past the date of the initial determination made on the claim
- RACs perform automated and complex reviews

What does and doesn't the RAC do?

- Automated reviews require no need for the RAC to request medical records
- Using their proprietary data mining techniques, the RAC can seek recoupment of overpayments on:
  - duplicate payments made for the same service on the same date
  - claims where a unit of service exceeds their allowed limit on units billed
  - services that may only be provided once in a lifetime but were billed more than once

What does and doesn't the RAC do?

- Complex reviews require the RAC to request medical records
- Limits on medical record requests a RAC may make in a 45 day period… 200 per NPI
  - CMS exploring the future use of a limit on the Tax Identification Number

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What does and doesn't the RAC do?

- In most cases, RACs are to make determinations on complex reviews within 60 days of receipt of the medical record
- Complex reviews will not be allowed until CMS has finalized their guidance on the medical records limits
- Potentially, complex reviews for medical necessity will not begin until early 2010

What does and doesn’t the RAC do?

- When the RAC sends you a demand letter, the “discussion period” begins
  - This period ends when a recoupment occurs or the RAC changes its decision
- If you wish to appeal, it is recommended that you quickly start the appeal process to stop recoupment
  - Refer to the CMS Medicare Medlearn Matters article MM6183 “Limitation on Recoupment”

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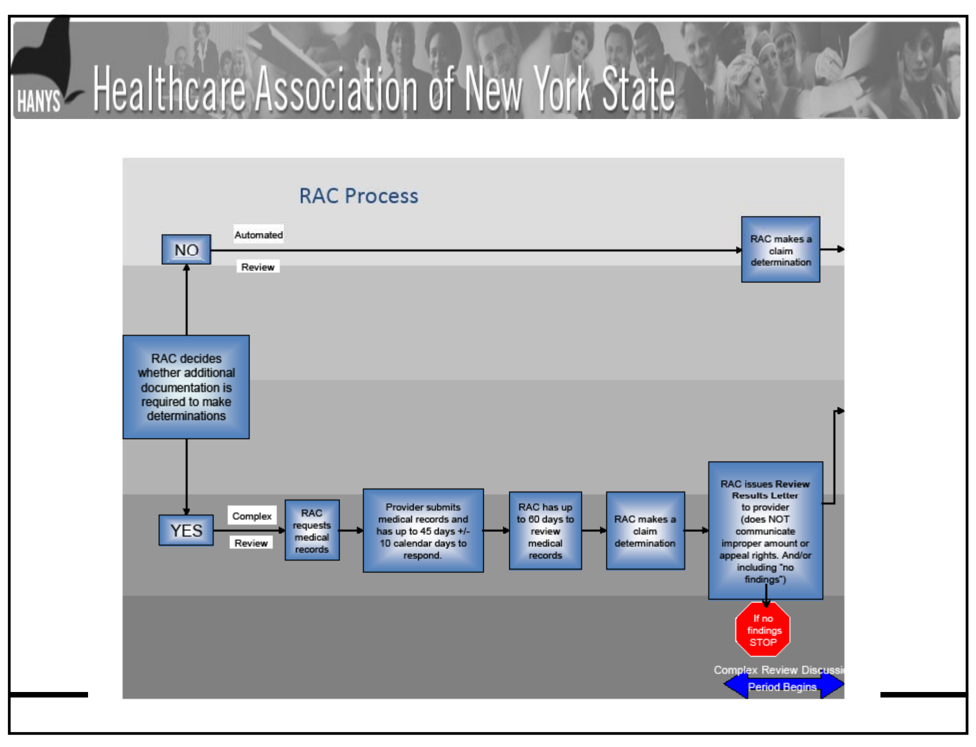

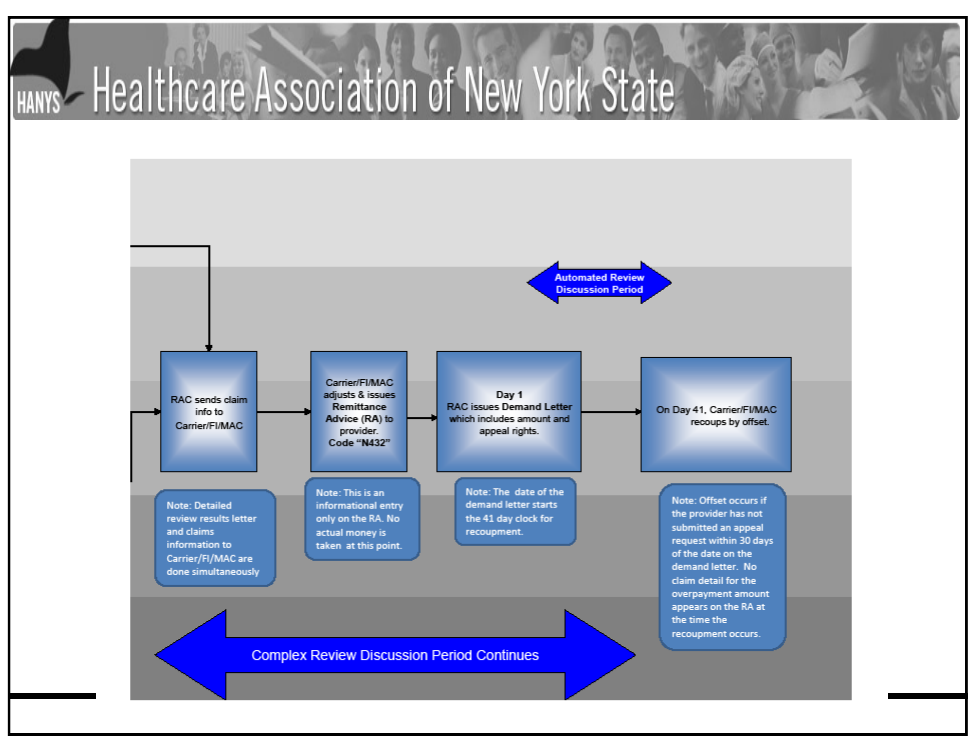

The New York Experience

- Established monthly conference calls between Provider Associations, CMS, RAC, and the Fiscal Intermediary
- Identified a RAC liaison at each hospital and encouraged the creation of a RAC team
- Provided outreach to each region of the state along with frequent elerts and updates
- Encouraged hospitals to use a tracking tool to follow the status of a claim targeted by the RAC
- Worked with CMS to establish medical record limits and timelines in the RAC process

The New York Experience

- Results of efforts were mixed
  - Each facility varied on its use of the tracking tool
  - The RAC process was not clear and had to be revised over time
  - The RAC was not always correct
  - Successfully advocated for underpayments to be incentivized
  - Advocated for CMS to allow hospitals to bill denied inpatient claims as outpatient

The New York Experience

- The RAC sometimes stopped recoupment when they were informed of mistakes
- Sometimes money was recouped even after mistakes were identified
- Providers could not track where a claim was in process after they sent medical records to the RAC
- Made appeals to Congress to correct problems encountered and to stop the RAC from expanding nationally

The New York Experience

- Top Inpatient Hospital RAC-targeted Overpayments
  - Surgical procedures in wrong setting (medically unnecessary)
  - Excisional debridement (incorrectly coded)
  - Treatment for heart failure and shock in wrong setting (medically unnecessary)
  - Respiratory system diagnoses with ventilator support (incorrectly coded)

The New York Experience

- Top Outpatient Hospital RAC-targeted Overpayments
  - Neulasta (medically unnecessary)
  - Speech-language pathology services (medically unnecessary)

The New York Experience

- Top Inpatient Hospital RAC-targeted Underpayments
  - ➢Wound debridement (incorrectly coded)
  - ➢Surgical procedures with an incorrect DRG (incorrectly coded)

- Top Outpatient Hospital RAC-targeted Underpayments
  - ➢Drug codes (incorrectly coded)
  - ➢Oxaliplatin (incorrectly coded)

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The New York Experience

- Average Overpayment Amounts per claim identified by the RAC
  - ➢Inpatient Hospital $12,157
  - ➢Outpatient Hospital $327
  - ➢Physician $140
  - ➢DME $174
- Conclusion: RACs went after high dollar claims

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What can you do now?

- Educate yourself by reviewing the CMS RAC web site at http://www.cms.hhs.gov/RAC/:
  - RAC Evaluation Report
  - RAC Statement of Work
  - RAC process: from demand letter to recoupment
  - The Medicare Appeals Process

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What can you do now?

- Learn what the CMS approved issues are in all the RAC Regions:
  - HDI RAC web site https://racinfo.healthdatainsights.com/
  - CGI's RAC web site: http://racb.cgi.com/
  - Diversified Collection Services www.dcsrac.com/
  - Connolly Consulting http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx

What can you do now?

HDI's contact numbers are as follows:

- Part A/Hospice: 866.590.5598
- Part B/DME: 866.376.2319
- Hospital & Hospice: 702.240.5595
- Physician/DME: 702.240.5510

What can you do now?

- Create a RAC Rapid Response Team at your facility
- Develop, research vendors who provide, or utilize the free AHA RAC claims tracking mechanism, and monitor the activity of RAC identified claims (available to non-members)
- Report on the AHA Quarterly Survey called RACTrac to assist your state and national efforts in advocating on your behalf
- http://www.aha.org/aha/issues/RAC/ractrac.html

What can you do now?

- Don't assume the RAC is correct when they issue demand letters
  - Work with your provider association
  - Providers are the front line in giving associations issues where they should focus
  - Notify them when you disagree with the RAC

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What can you do now?

- 82 of Iowa's 117 hospitals are CAHs so look at the data that the RAC may target for incorrect coding or medical necessity
- Sample your top Inpatient One Day Stays to see if your facility is higher or lower than the state or national average
- Sample your transfers to a SNF by length of stay to see if your facility is higher or lower than the state or national average
- Sample the RAC issues already being addressed

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One Day Length of Stay Report - Selected Medical Diagnoses

MS-DRG	Description	US		Iowa	
		Total Discharges	% One Day Stays	Total Discharges	% One Day Stays
MEDICAL					
313	Chest pain	381,787	46%	1,615	54%
392	Esophagitis, gastroent & misc digest disorders w/o MCC	821,972	18%	2,358	18%
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	343,854	29%	1,505	32%
312	Syncope & collapse	493,129	23%	1,194	26%
287	Circulatory disorders except AMI, w card cath w/o MCC	404,334	27%	1,519	30%
641	Nutritional & misc metabolic disorders w/o MCC	648,446	15%	1,864	14%
069	Transient ischemia	278,575	23%	733	27%
812	Red blood cell disorders w/o MCC	313,046	22%	645	21%
690	Kidney & urinary tract infections w/o MCC	761,615	9%	1,564	10%
293	Heart failure & shock w/o CC/MCC	457,955	12%	1,185	11%
SURGICAL					
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	311,426	53%	2,672	59%
039	Extracranial procedures w/o CC/MCC	82,081	65%	698	77%
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	170,910	41%	969	46%
491	Back & neck proc exc spinal fusion w/o CC/MCC	104,618	48%	769	53%
254	Other vascular procedures w/o CC/MCC	115,120	47%	602	62%
244	Permanent cardiac pacemaker implant w/o CC/MCC	140,430	39%	771	54%
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	91,024	57%	564	71%
251	Perc cardiovasc proc w/o coronary artery stent w/o MCC	102,645	45%	429	51%
473	Cervical spinal fusion w/o CC/MCC	44,516	60%	184	63%
714	Transurethral prostatectomy w/o CC/MCC	48,793	46%	293	30%

Data Source: 2008 Medicare inpatient claims data
Excludes: Transfers to Acute Care, Left Against Medical Advice, Deaths
US Data Excludes: Maryland, Puerto Rico, Virgin Islands

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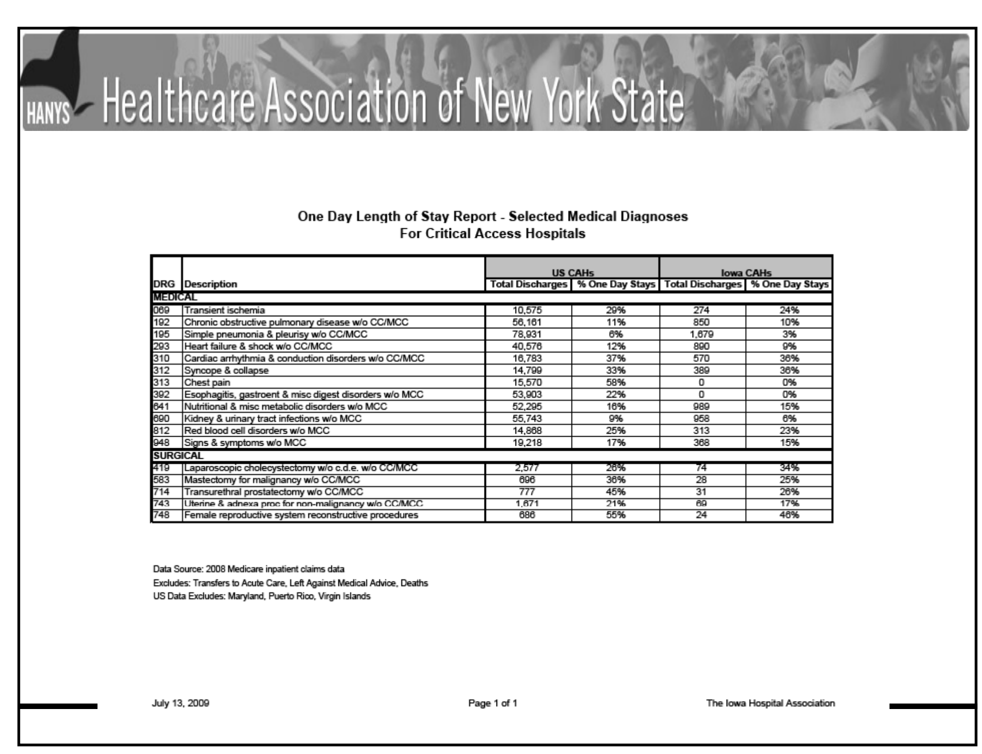

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One Day Length of Stay Report - Selected Medical Diagnoses For Critical Access Hospitals

DRG	Description	US CAHs		Iowa CAHs	
		Total Discharges	% One Day Stays	Total Discharges	% One Day Stays
MEDICAL					
069	Transient ischemia	10,575	29%	274	24%
192	Chronic obstructive pulmonary disease w/o CC/MCC	56,161	11%	850	10%
195	Simple pneumonia & pleurisy w/o CC/MCC	78,931	6%	1,679	3%
293	Heart failure & shock w/o CC/MCC	40,576	12%	890	9%
310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	16,783	37%	570	36%
312	Syncope & collapse	14,799	33%	389	36%
313	Chest pain	15,570	58%	0	0%
392	Esophagitis, gastroent & misc digest disorders w/o MCC	53,903	22%	0	0%
641	Nutritional & misc metabolic disorders w/o MCC	52,295	16%	989	15%
690	Kidney & urinary tract infections w/o MCC	55,743	9%	958	6%
812	Red blood cell disorders w/o MCC	14,868	25%	313	23%
948	Signs & symptoms w/o MCC	19,218	17%	368	15%
SURGICAL					
419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	2,577	26%	74	34%
583	Mastectomy for malignancy w/o CC/MCC	696	36%	28	25%
714	Transurethral prostatectomy w/o CC/MCC	777	45%	31	26%
743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	1,671	21%	69	17%
748	Female reproductive system reconstructive procedures	686	55%	24	46%

Data Source: 2008 Medicare inpatient claims data
Excludes: Transfers to Acute Care, Left Against Medical Advice, Deaths
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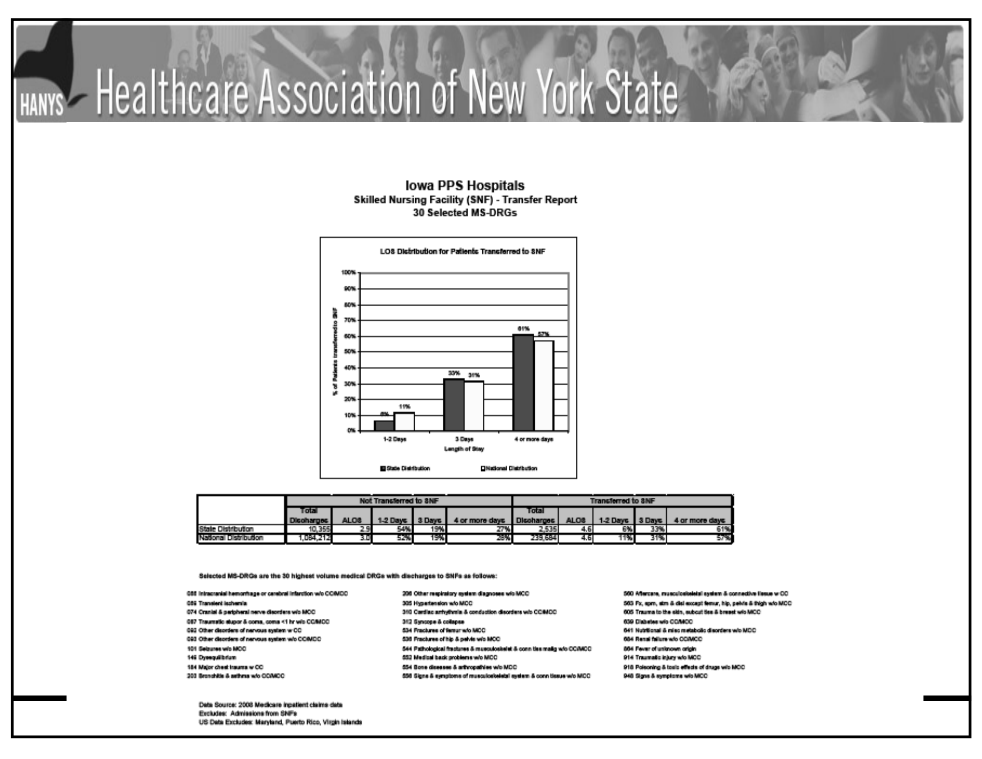
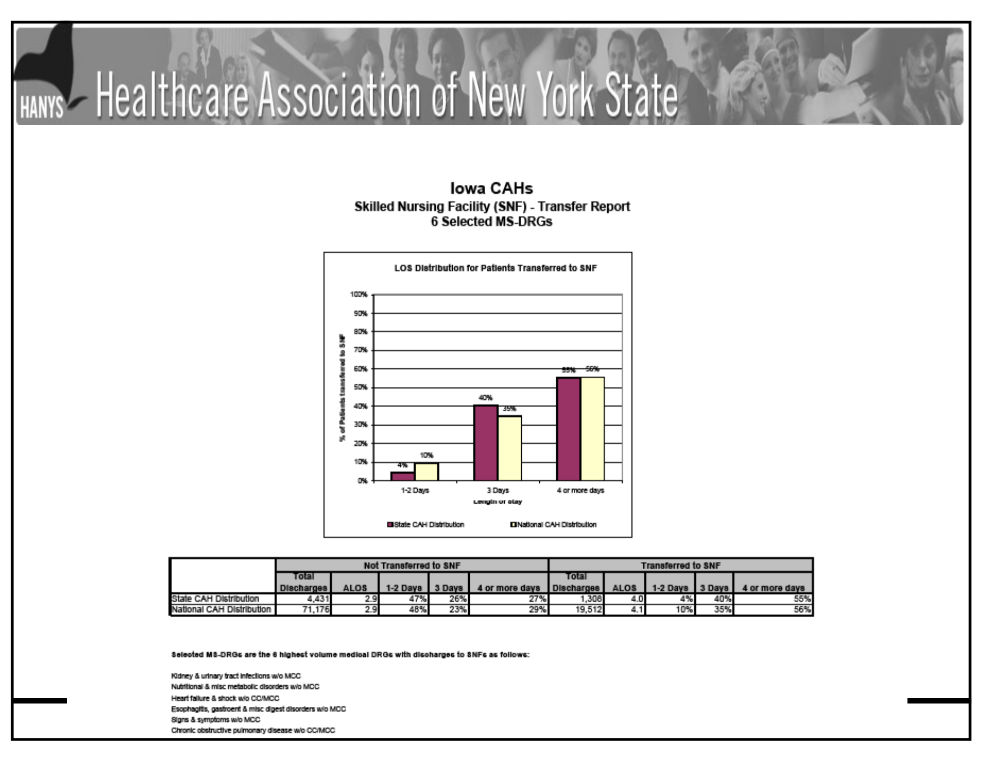


	Not Transferred to SNF					Transferred to SNF				
	Total Discharges	ALOS	1-2 Days	3 Days	4 or more days	Total Discharges	ALOS	1-2 Days	3 Days	4 or more days
State Distribution	10,355	2.9	54%	19%	27%	2,535	4.6	6%	33%	61%
National Distribution	1,084,212	3.0	52%	19%	28%	239,684	4.6	11%	31%	57%

Selected MS-DRGs are the 30 highest volume medical DRGs with discharges to SNFs as follows:

066 Intracranial hemorrhage or cerebral infarction w/o CC/MCC
069 Transient ischemia
074 Cranial & peripheral nerve disorders w/o MCC
087 Traumatic stupor & coma, coma <1 hr w/o CC/MCC
092 Other disorders of nervous system w CC
093 Other disorders of nervous system w/o CC/MCC
101 Seizures w/o MCC
149 Dysequilibrium
184 Major chest trauma w CC
203 Bronchitis & asthma w/o CC/MCC
206 Other respiratory system diagnoses w/o MCC
305 Hypertension w/o MCC
310 Cardiac arrhythmia & conduction disorders w/o CC/MCC
312 Syncope & collapse
534 Fractures of femur w/o MCC
536 Fractures of hip & pelvis w/o MCC
544 Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC
552 Medical back problems w/o MCC
554 Bone diseases & arthropathies w/o MCC
556 Signs & symptoms of musculoskeletal system & conn tissue w/o MCC
560 Aftercare, musculoskeletal system & connective tissue w CC
563 Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC
605 Trauma to the skin, subcut tiss & breast w/o MCC
639 Diabetes w/o CC/MCC
641 Nutritional & misc metabolic disorders w/o MCC
684 Renal failure w/o CC/MCC
864 Fever of unknown origin
914 Traumatic injury w/o MCC
918 Poisoning & toxic effects of drugs w/o MCC
948 Signs & symptoms w/o MCC

Data Source: 2008 Medicare inpatient claims data
Excludes: Admissions from SNFs
US Data Excludes: Maryland, Puerto Rico, Virgin Islands



	Not Transferred to SNF					Transferred to SNF				
	Total Discharges	ALOS	1-2 Days	3 Days	4 or more days	Total Discharges	ALOS	1-2 Days	3 Days	4 or more days
State CAH Distribution	4,431	2.9	47%	26%	27%	1,306	4.0	4%	40%	55%
National CAH Distribution	71,176	2.9	48%	23%	29%	19,512	4.1	10%	35%	56%

Selected MS-DRGs are the 6 highest volume medical DRGs with discharges to SNFs as follows:

Kidney & urinary tract infections w/o MCC
Nutritional & misc metabolic disorders w/o MCC
Heart failure & shock w/o CC/MCC
Esophagitis, gastroent & misc digest disorders w/o MCC
Signs & symptoms w/o MCC
Chronic obstructive pulmonary disease w/o CC/MCC

Potential Future Issue

•Senator Baucus' Chairman's Mark includes language that would expand the RAC to Medicare Parts C, D and Medicaid by the end of 2010

Questions?

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