RECOVERY AUDIT CONTRACTORS

RAC SUBSCRIPTION SERVICE

"Being Proactive"

February 8, 2011

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RAC Subscription Service: Webinar Overview

- "RACs: Being Proactive"
  - Second Tuesday of each month
  - Discuss one or two high-risk areas for RAC review
  - Review ideas on how to proactively audit
  - Propose operational safeguards

- "RACs: What are We Learning"
  - Fourth Tuesday of each month
  - Keep subscribers up-to-date on RAC developments
    - Discuss RAC updates
    - Analyze publicly available decisions involving RACs
  - Pool questions from subscribers

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RAC Subscription Service: Webinar Overview

- Regularly scheduled Webinars will be supplemented, as necessary, with special “emergency” sessions

- Administrative Matters
  - Each session will be 60-75 minutes in duration, including a question and answer session
  - Each session will begin at 12:00 PM CT
  - If you are unable to participate in the live discussion, each session will be recorded and made available in MP3 format

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Goals

- The goals of the RAC Webinars:
  - Teaching/knowledge transfer
  - Practical points
  - Assist organizations to develop in-house methods of managing
  - Please share your thoughts, suggestions (and criticisms)

- Our Perspective—
  - *Defend your claims*: Appeals process is critical
  - *Manage your compliance risks*: Compliance implications to a RAC review must be addressed – the RAC process is not just about RAC recovery
  - *Be proactive*…and preemptive

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Today's Topics and Agenda

- Medicaid Program RACs—an update
- Federal government's support of Medicaid program integrity/cost reduction initiatives
- AHA Letter in regard to regulations that negatively impact hospitals
- OIG publishes ACA final rule to prevent healthcare fraud
- New CMS Announcements/Releases:
  - Inpatient admission decisions (January 25, 2011)
  - Implications of new timely filing requirements (January 26, 2011)
  - GZ Modifier clarification (February 4, 2011)

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Medicaid Program RACs

- On November 9, 2010, we spoke at length about the planned expansion of the RAC program to state Medicaid programs, as per ACA
- On November 5, 2010, CMS released a proposed rule that would codify the Affordable Care Act provisions (published on November 10, 2010)
- State plan amendment required by December 31, 2010
- Implementation by April 1, 2011

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Medicaid Program RACs

- In a February 1, 2011 informational bulletin, CMS announced that States need **not** implement their Medicaid RAC programs by April 1, 2011.

- Implementation delayed until such time as a final rule is published
  - Publication of a final rule is expected "later this year"

- Somewhat surprising development given statutory mandate, but implementation date seemed impractical

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HHS Letter to States in regard to Medicaid Program Support

- Last week, Secretary Sebelius also issued a letter to state governors.
- Letter emphasized:
  - Enhanced Federal match for Medicaid through June, 2011
  - Greater flexibility for State plan amendments/waivers
  - Potential cost saving areas, including
    - Modified optional benefits
    - Managing high cost enrollees (1% of Medicaid recipients account for 25% of all expenditures) through new programs (e.g., home health for persons with chronic conditions)

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HHS Letter to States in regard to Medicaid Program Support

- Potential cost saving areas, including
  - Purchase drugs more efficiently (generics, mail order, better management of over-prescribed drugs)
  - Program integrity efforts
    - HHS 2010 Financial Agency Report = 3-year weighted average national Medicaid error rate is 9.4%
    - 9.4% error rate = $33.7 billion in state and federal funds were paid inappropriately
    - Federal government has a shared interest with the States in assuring program integrity

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HHS Letter to States in regard to Medicaid Program Support

- Program integrity Federal resources available to States include:
  - Best practice webinars
  - Medicare program and private sector initiatives that may be replicated by state Medicaid programs
    - Access to federal database of terminated providers
    - States will be able to use federal audit contractors
    - Access to analytics and predictive modeling
    - See discussion of ACA final rule, below
- Sec. Sebelius wrote: "The President is committed to cutting the error rate in half by 2012."

- Takeaway: Even with a delayed Medicaid RAC program implementation, States and federal government will be focused upon reducing Medicaid errors

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AHA Letter to House Committee on Oversight and Government Reform

- By letter dated January 14, 2011, AHA responded to an invitation to address federal regulations that negatively impact hospitals
- AHA identified a number of federal laws and regulations that negatively impact clinical integration and care coordination, including:
  - Antitrust laws
  - Stark Law
    - Remove compensation arrangements from the definition of financial relationships that are subject to the Stark Law
  - CMP Law
    - Amend to make it clear that law applies only to reduction or withholding of medically necessary services
  - AKS
    - No safe harbor for clinical integration
  - IRS Code
    - Private benefit/inurement limits on physician payments for clinical integration

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AHA Letter to House Committee on Oversight and Government Reform

In addition to the federal rules and regulations negatively impacting clinical integration efforts, the AHA letter also addressed several other areas, including:

- RACs
  - "Fundamental flaws in the design and operation of the Medicare RAC demonstration program led to provider appeals, 64 percent of which were decided in favor of the provider."
  - "More than 50 percent of hospitals report a significant increase in administrative burden due to the RAC program, including employing additional compliance staff and consultants."
- Abuse of FCA
  - Data analysis that flag billing errors and/or over-utilization and convert into a presumption of FCA liability.

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AHA Letter to House Committee on Oversight and Government Reform

- EHR Certification
  - Meaningful use rules are too complex and onerous

- Clinical Laboratory Signature on Requisition
  - Unnecessary and too onerous
  - In December of 2010, CMS announced an enforcement delay of his requirement until after the first calendar quarter of 2011

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ACA Final Rule to Prevent Fraud

- On September 23, 2010, CMS published a proposed rule implementing provisions of the ACA
  - Screening Medicare, Medicaid, CHIP providers and suppliers
  - Application fee
    - $500 for institutional providers/suppliers
  - Temporary moratoria that may be imposed if necessary to combat fraud, waste and abuse
  - Termination of Medicaid providers and suppliers
  - Suspension of payments pending credible allegations of fraud

75 Fed. Reg. 58204 (Sept. 23, 2010)

Discussed in our September 28, 2010 webinar

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ACA Final Rule to Prevent Fraud

- Final Rule published on February 2, 2011
  - Requires states to screen providers who order or refer Medicaid beneficiaries to determine if such providers have previously defrauded the government, and, if found to have been excluded from Medicare or another State's Medicaid or CHIP, to bar them from all Medicaid and CHIP programs; and
  - Using predictive data software designed to detect healthcare fraud, and if so detected within a category of providers or geographic area, to temporarily stop enrollment provided that it does not impact patient access to care.
- CMS declined to issue a final rule regarding the mandatory compliance programs required under the ACA. Stated that it would issue a separate rulemaking on that in the future.

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"Guidance on Hospital Inpatient Admission Decisions" (Jan 25, 2011)

- CMS released a "MedLearn Matters" on January 25, 2011 (SE1037) which addresses complaints about how RACs and other contractors are reviewing inpatient admissions.

- CMS:
  - "Some hospitals have recently expressed concern about how the Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractors (RACs), MACs, FIs, and the Comprehensive Error Rate Testing Contractor (CERT) are utilizing screening criteria to analyze medical documentation and make a medical necessity determination on inpatient hospital claims."

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"Guidance on Hospital Inpatient Admission Decisions" (Jan 25, 2011)

- CMS refers providers to the following cites:
  - Medicare Program Integrity Manual, Ch. 6, Sec. 6.5.1
    - Requires contractors, including RACs, to use a tool, but the contractor is not bound by the tool. Sufficiency for inpatient coverage is a case-by-case determination.
    - **"In all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record."** (emphasis in original)

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"Guidance on Hospital Inpatient Admission Decisions" (Jan 25, 2011)

- CMS refers providers to the following cites:
  - Medicare Program Benefit Manual, Ch. 1, Sec. 10
    - "The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark (i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis)."
    - Sec. 10 generally discusses three possibilities of inpatient billing errors:
      - Unwarranted inpatient admission
      - Wrong DRG
      - Inappropriate outlier payments due to non-covered items and services listed as covered

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"Guidance on Hospital Inpatient Admission Decisions" (Jan 25, 2011)

- CMS conclusion (note: the discussion in the MLN Matters is more significant than CMS's conclusion):
  - "It is important that any staff involved with the clinical decision to admit the patient stay abreast of all CMS national inpatient hospital policy and National and Local Coverage Determinations. Additionally, make sure medical documentation submitted demonstrates evidence of the clinical need for the patient to be admitted to the inpatient facility and fully and accurately identifies any subsequent care that was provided during the inpatient stay."

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CMS issues reminder of new Medicare timely filing requirements (Jan 26, 2011)

- CMS issued a MedLearn Matter (MM7270) discussing the change in claim filing periods:
  - "Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the Medicare Claims Processing Manual (Chapter 1) pertaining to the time limits for filing Medicare claims."
  - There are limited exceptions associated with:
    - "administrative error" on the part of a government or Medicare contractor employee
    - "retroactive Medicare entitlement"
    - Exceptions allow additional six months from notice

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CMS issues reminder of new Medicare timely filing requirements (Jan 26, 2011)

- RAC and Compliance Implications:
  - Refunding and rebilling errors from shadow audits will be more difficult with a shorter timely filing period
    - Choose time frames carefully when doing audits
  - Compliance “bill holds” must be “scrubbed” quicker or revenue will be lost
    - If a serous compliance issue occurs and a bill hold occurs, the one year deadline will pass more quickly than everyone anticipates

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GZ Modifier Clarification (February 4, 2011)

- CMS issued clarification (CR7228) that Medicare Contractors, including RACs, are not to conduct complex medical reviews on any line item that contains the GZ modifier. Any charge with a GZ is to be automatically denied.

- CMS:
  - "The GZ modifier indicates that an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy."
  - "All MACs shall make all language published in educational outreach materials, articles, and on their Web sites, consistent to state all claim line(s) items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review."

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GZ Modifier Clarification (February 4, 2011)

- Currently the GZ denial is technically a matter of discretion for the Contractors, and currently likely will adjudicate it as a denial

- But…example of how some MACs deal with it. WPS published on Jun 29, 2009 the follow:

  - "This modifier is an informational modifier only.
  - "Medicare will adjudicate the service just like any other claim.
  - "If Medicare determines that the service is not payable, denial is under a "medical necessity." The denial message will indicate that the patient is not responsible for payment.
  - "If either the beneficiary or provider requests a review, the modifier tells us that an ABN was not given and this could help in completing the review quickly."

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GZ Modifier Clarification (February 4, 2011)

- Change is technically effective July 1, 2011
- There is no obligation to bill any service which would use a GZ because the provider anticipates that the service is not covered, but if provider believes there is reason to bill for a denial, then use it
- What does this mean? This seems to be a swipe at the Contractors which may be paying claims submitted with a GZ, while providers are able to say “we disclosed”

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GZ Modifier Clarification (February 4, 2011)

- What are the implications for RACs?
  - It's not entirely clear why the instruction extends to RACs.
  - Presumably the RAC would not perform a review on any charge which was denied
  - Though it's unlikely this instruction applies to RACs review of past claims in which charges with a GZ were factored into the reimbursement calculation. It would seem to serve as a signal to the RAC to double-check the MAC's adjudication of the GZ line items they paid.
  - Watch for any RAC reviews of claims which contain GZ modifiers on line items and see if there are connections to the GZ if there is a demand letter

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Follow-Up

- Questions?

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- Next Lecture:

Tuesday, February 22, 2011

12pm CT/1pm ET

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