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RAC attack: How providers can be prepared

- » RACs recovered \$797 million in Medicare overpayments in FY 2011.
- » In FY 2012, the reach of the RACs extends further.
- » CMS is working to implement Medicare Part C and D RACs.
- » State enforcement efforts will increase with the introduction of Medicaid RACs.
- » Providers must prepare by evaluating and modifying corporate compliance programs.

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A word of caution to health care providers—RACs are here to stay and their reach only continues to extend. In fiscal year (FY) 2011, Recovery Audit Contractors (RACs) recovered \$797 million in Medicare overpayments. During the same period, the RACs returned \$142 million in underpayments to hospitals and other providers participating in Medicare Part A and Part B.¹ Moving into the early part of 2012, the government appears to be continuing its focus on auditing, investigating, prosecuting, and excluding health care providers for fraud. RACs recovered \$398 million in Medicare overpayments during the first quarter of FY 2012, a 44% increase from the \$277 million recovered the previous quarter, according to a recent report released by the Centers for Medicare & Medicaid Services (CMS). During the same period, the RACs returned \$25 million in underpayments to hospitals and providers, a 68% decline from the \$77 million returned in the fourth quarter of FY 2011.² As such, RACs and their contractor counterparts—the Comprehensive Error Rate Testing

(CERT) program and Zone Program Integrity Contractors (ZPICs)—will continue to be key instruments in the government's fight against health care fraud.

What can health care providers do to be prepared? Providers that have embraced the responsibilities of compliance by developing and adopting robust compliance programs are best positioned to weather these enhanced regulatory threats. By contrast, providers that have not fully embraced compliance as a culture, returned overpayments routinely, or corrected potential problems, should consider implementing a robust compliance program.

A brief history of the RAC program

The RAC program was created through the Medicare Modernization Act of 2003 (MMA) to identify and recover improper Medicare payments paid to health care providers. In Section 306 of the MMA, the U.S. Department of Health and Human Services (DHHS), through CMS, was required to conduct a 3-year demonstration program to determine whether the use of RACs would be a cost-effective means of



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adding resources to ensure correct payments are being made to providers and suppliers. The demonstration project began in 2005 and operated in New York, Massachusetts, Florida, South Carolina and California, before ending in March 2008. Under Section 302 of the Tax Relief and Health Care Act of 2006, DHHS was required to establish the program for all states by January 1, 2010.

RACs are currently reviewing claims from all Medicare fee-for-service (FFS) billers that participate in the Part A and Part B programs. The RAC program divides the country into four jurisdictions, each under the control of a separate contractor:

- ▶ Region A (New England and Mid-Atlantic states): audited by Diversified Collection Services;
- ▶ Region B (Midwestern states): audited by CGI;
- ▶ Region C (Southern and Southwestern states): audited by Connolly, Inc.; and
- ▶ Region D (Western and Pacific states) audited by HealthDataInsights, Inc.

Each RAC may subcontract portions of its region. PRG Shultz subcontracts for portions of Regions A, B and D, iHealth Technologies and Strategic Health Solutions also subcontract portions of Region A, and Viant subcontracts portions of Region C.

RACs review claims on a post-payment basis and according to the same Medicare guidance and policies (National Coverage Determinations, Local Coverage Determinations, and CMS Manuals) used by Carriers, Fiscal Intermediaries and Medicare Administrative Contractors (MACs). The RACs may apply their own internal methods and tools to identify potential claims for review. However, the RACs may not develop or apply their own coverage, coding, or billing policies. RACs may conduct two different types of review: (1) automated, where no medical records are needed, and (2) complex, where

medical records are required. RACs are able to review claims that date back to October 1, 2007, but may only review three years from the date the claim was paid. RACs must have a staff consisting of nurses, therapists, certified coders, and a physician certified medical director (CMD).

The RACs are paid on a contingency fee basis and the amount of the fee is based on the amount of money recovered from, or reimbursed to, the providers. The fee is a percentage of the dollar amount of the improper payment and is paid to the RAC once the money is recouped or refunded. In FY 2009 and FY 2010, the contingency fees ranged from 9% to 12.5%. If a RAC is paid a contingency fee for a particular over- or underpayment and it is subsequently overturned at any level of appeal, the RAC must return the fee.³

What we have learned from the RACs so far

FY 2010 was the first year during which the RACs actively identified and corrected improper payments through the national Recovery Audit Program. In FY 2010, the program included only Medicare FFS audits. During FY 2010, the RACs identified and corrected \$92.3 million in both overpayments and underpayments. However, during the same time period, the RACs actually demanded \$135.6 million in overpayments. To date, only 2.4% of claims collected during FY 2010 have been both challenged and overturned on appeal. The RAC program has recovered \$1.27 billion in overpayments and has returned \$184 million in underpayments to providers since the program began in October 2009.²

CMS has been tracking major findings of the RACs, known as vulnerabilities, for the purpose of developing corrective actions. CMS has posted the top vulnerabilities on its website and also publishes quarterly newsletters to educate providers. Examples of “top issues” identified by the RACs include:

- ▶ **Ventilator support of 96+ hours:** Ventilation hours begin with the intubation of the patient (or time of admittance if the patient is admitted while on mechanical ventilation) and continue until the endotracheal tube is removed, the patient is discharged/transferred, or the ventilation is discontinued after a weaning period. Providers are improperly adding the number of ventilator hours, resulting in higher reimbursement. (Region A – Incorrect Coding)
- ▶ **Extensive operating room procedure unrelated to principal diagnosis:** The principal diagnosis and principal procedure codes for inpatient claims should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis-Related Group (MS-DRG) assignment. (Region B – Incorrect Coding)
- ▶ **Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided during an inpatient stay:** Medicare does not make separate payments for DMEPOS when beneficiaries are in covered inpatient stays. Suppliers are inappropriately receiving separate DMEPOS payments when beneficiaries are in covered inpatient stays. (Regions C and D – Billing for Bundled Services Separately).³

CMS has put processes in place for identifying and tracking the issues that the RACs examine. For example, when the RACs submit claims information to the Data Warehouse, they report information such as the number of claims with improper payments, a description of the issue(s), provider type, error type, and whether an improper payment was identified through automatic or complex review. Additionally, the RACs must report to CMS the dollar amounts collected or refunded,

and any related appeals statistics. Further, with each new review, the RACs provide CMS with a short description of the improper payment, the codes affected, and a reference that describes why the issue resulted in an improper payment.

What's on the horizon for RACs?

The Patient Protection and Affordable Care Act (ACA) expanded the reach of the RAC program, to cover Medicare Part C and Part D in 2012. The ACA specifically requires that RAC contractors for Medicare Part C and Part D be engaged by the Secretary of DHHS:

- ▶ to ensure that each Medicare Advantage plan and Part D plan has an anti-fraud plan in place and to review the effectiveness of the plan;
- ▶ to examine claims for reinsurance payments to determine whether prescription drug plans that submit these claims incurred costs in excess of the allowable reinsurance costs permitted under ACA;
- ▶ to review estimates submitted by prescription drug plans by private plans with regard to the enrollment of high cost beneficiaries, and to compare these estimates with the numbers of beneficiaries actually enrolled by the plans.⁴

CMS has taken several steps towards the implementation of Part C and Part D RACs. In December 2010, CMS published a solicitation for public comments, requesting industry feedback on several key issues arising under the pending RAC program expansion.⁵ In January 2011, CMS awarded a contract for Part D recovery auditing to ACLR Strategic Business Solutions. As of July 2011, a specific date for initiation of recovery audits had not yet been established; however, prior to launching the expansion of the RAC program, the Part D RAC has been working to fulfill CMS systems access requirements, developing outreach plans

to Part D sponsors, and working with CMS to establish priorities for recovery auditing.

Section 6411 of the ACA also required that states and territories establish Medicaid RAC programs by December 31, 2010. In October 2010, CMS issued a State Medicaid Director Letter to provide initial guidance on the implementation of these RAC programs. Each state and territory was required to submit a State Plan Amendment (SPA) to CMS, in order to establish a state Medicaid RAC program subject to the exceptions and requirements provided by the Secretary of HHS. As of May 2011, CMS had granted a total of 14 exception requests from states and territories. The two largest sub-categories of exceptions were (1) requests from states for delay of implementation, and (2) complete exemption from implementing a RAC program on the basis of Medicaid claims system infrastructure challenges. CMS published a Notice of Proposed Rule Making in November 2010 and subsequently issued the final rule in September 2011.⁶

The originally proposed implementation date of April 1, 2011 was delayed in order to allow states sufficient time to develop their RAC programs. States have been working to implement their Medicaid RAC programs and CMS continues to provide support to the states during the implementation process. In February 2011, CMS launched its “Medicaid RACs At-A-Glance” website (www.cms.gov/medicaidracs), which has basic information about the status of each state’s RAC program and details related to the exception requests that were submitted. CMS intends to enhance the website with information regarding state Medicaid RAC program performance, and will be working with states to establish performance measures for the state Medicaid RAC programs.

CMS announced in late December 2011 that the agency will delay a demonstration

project that would have allowed RACs to review claims before they are paid.⁷

The demonstration project, announced in November 2011, would allow RACs to conduct pre-payment reviews on certain types of claims that historically result in high rates of improper payments. The reviews would focus on a group of seven states with higher-than-average numbers of fraud and error prone providers (California, Florida, Illinois, Louisiana, Michigan, New York, and Texas) and an additional four states with high claims volumes of short inpatient hospital stays (Missouri, North Carolina, Ohio, and Pennsylvania). RACs will review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The intent behind the demonstration project is to help lower fraud and error rates by preventing improper payments, rather than relying on the traditional “pay and chase” methods of looking for improper payments after they have occurred. In late December 2011, CMS announced that this demonstration project is delayed until further notice.

What can providers do to be prepared?

As the efforts of the RACs continue to expand around the country, it is more important than ever for providers to make sure their processes for documentation, billing, and coding are accurate and comprehensive. To avoid the reach of RACs, providers must take the important steps to analyze and evaluate their compliance programs. After this review, providers must adopt any updates to their compliance programs, such as policy revisions, staff training, and regular audits to ensure processes are thoroughly implemented. Efforts made by providers to assess and prepare for the reach of the RACs will be time and effort well spent.

As state enforcement efforts increase with the introduction of Medicaid RACs, providers need to be aware of any state-specific requirements, because the audit rules will vary by state. Providers must exercise due diligence to understand the rules of each of the Medicaid RAC programs in states where they have entities, as far as types of claims audited, number and frequency of medical record reviews, response timeframes for additional documentation requests, external validation of RAC finding accuracy, additional RAC requirements, and possible exemptions. ☐

1. Centers for Medicare & Medicaid Services: *Medicare Fee-for-Service Recovery Audit Program: FY 2011*. Available at <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011Corrections.pdf>
2. CMS: *Medicare Fee-for-Service National Recovery Audit Program Quarterly Newsletter* (Oct. 1, 2011-Dec. 31, 2011). Available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RecoveryAuditProgram_1st_qtr2012_vj.pdf. See also CMS: *Medicare Fee-for-Service National Recovery Audit Program Quarterly Newsletter* (July 1, 2011-Sept. 30, 2011). Available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011QtrlyReport.pdf>
3. CMS: *Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services: FY 2010 Report to Congress as Required by Section 6411 of Affordable Care Act*. Available at <https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf> (hereinafter, CMS FY 2010 Report).
4. Affordable Care Act, Section 6411(b)(5). The Affordable Care Act consists of H.R. 3590 (the Patient Protection and Affordable Care Act) and H.R. 4872 (the Health Care and Education Reconciliation Act of 2010).
5. See 75 Fed. Reg. 81278 (Dec. 27, 2010).
6. See 75 Fed. Reg. 69037 (Nov. 10, 2010); 76 Fed. Reg. 57808 (Sept. 16, 2011).
7. Rich Daley: "CMS Holds Off on Two Anti-Fraud Projects." *Modern Healthcare*, Dec. 30, 2011. Available at <https://home.modernhealthcare.com>.

More information

For more information about the Medicare RAC program, see www.cms.gov/rac.

For more information about the Medicaid RAC program, see www.cms.gov/medicaidracs and www.medicaid-rac.com.

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The Fraud and Compliance Forum is jointly sponsored by the Health Care Compliance Association (HCCA) and the American Health Lawyers Association (AHLA). It will include an explicit designation of a session as "compliance focused" or "legal focused." The Planning Committee has included enough sessions in each designation that an individual could attend all "compliance" sessions or all "legal" sessions for the entire program. Yet an attendee also has the option of selecting a diversity of sessions and networking with an expanded group of individuals. The Fraud and Compliance Forum has the benefit of combining the quality of HCCA and AHLA sessions with the expanded networking power of a combined program.

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