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RAC Roundup: Preparing For The Prepayment Review Demonstration Project

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As part of continued efforts to expand the Medicare Recovery Audit Contractor (RAC) program, in November 2011 the Centers for Medicare & Medicaid Services (CMS) announced the implementation of a demonstration project that would allow RACs to conduct prepayment reviews on certain types of Medicare claims. This demonstration project is intended to lower error rates by preventing improper payments rather than identifying improper payments after they have been made.^[1] Originally slated to begin in January 2012, the demonstration project is expected to begin in the summer of 2012.

The introduction of the demonstration project reflects an ongoing dilemma—balancing the importance of Medicare program integrity initiatives against the effect that prepayment review has on Medicare providers. Providers should consider that this demonstration project will not simply be a one-year trial; instead, it will evolve to become the new model for RAC reviews. As such, providers should take the necessary steps to assess, analyze, and, as needed, make investments to improve internal auditing and monitoring policies, procedures, and processes.

Background of the RAC Program

The original RAC program was implemented in 2005 as a pilot in five states (California, Florida, Massachusetts, New York, and South Carolina) under Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.^[2] The three-year pilot ended in March 2008, and Section 302 of the Tax Relief and Health Care Act of 2006 then expanded the pilot to a permanent national program to be implemented by January 2010.^[3] All of the RACs began reviewing claims in October 2009, and fiscal year (FY) 2010 was the first year in which the RACs began actively identifying and correcting

improper payments under the national program. In FY 2010, the RACs identified and corrected \$92.3 million in combined overpayments and underpayments.[\[4\]](#) By contrast, in the first quarter of 2012, the RACs collected \$588.4 million in overpayments and returned \$61.5 million in underpayments.[\[5\]](#)

RACs historically have been tasked with detecting and correcting *past* improper payments (overpayments and underpayments), and may do so by applying statutes, regulations, CMS coverage and billing policies, and local coverage determinations (LCDs) to make these determinations. Currently, there are four RAC regions, each handled by a different contractor.[\[6\]](#) Section 6411(b) of the Patient Protection and Affordable Care Act of 2010 expanded the reach of the RACs to all Medicare claims and not just Part A and B claims. CMS also has begun implementation of Part C and D RACs, as well as the Medicaid RAC program.[\[7\]](#)

The RACs are strongly supported by the federal government, in particular as the Obama administration has moved aggressively to reduce the amount of improper payments made throughout the federal healthcare system. A number of initiatives recently have been implemented by the federal government that suggest an increased focus on reducing improper payments to providers and holding agencies accountable and creating strong incentives for compliance. Among these initiatives was the President's statement in June 2010 announcing that his administration would cut the improper payment rate in the Medicare fee-for-service program in half by 2012 to eliminate more than \$20 billion in payment errors.[\[8\]](#) In July 2010, the President signed into law the Improper Payments Elimination and Recovery Act (IPERA), with the goal of improving agency efforts to reduce and recover improper payments in several ways, including by the identification and estimation of improper payments, payment recapture audits, the use of recovered improper payments, and compliance and non-compliance requirements.[\[9\]](#)

CMS has developed several demonstration projects to target some of the most common factors that lead to improper payments. In addition to the RAC prepayment review demonstration project, CMS announced two additional demonstration projects in November 2011. The first one, the prior authorization demonstration project, will be a three-year project that will require prior authorization for certain medical equipment for all Medicare beneficiaries who reside in seven states thought to have high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). The prior authorization project will occur in two phases, the first being prepayment reviews on certain medical equipment claims, and the second being the implementation of prior authorization by CMS. The second project will focus on Part A to Part B rebilling, allowing hospitals to rebill for 90% of the Part B payment when a Medicare contractor (Medicare Administrative Contractor (MAC), RAC, or Comprehensive Error Rate Testing (CERT)) denies a Part A inpatient short-stay claim as not reasonable

and necessary due to the hospital billing for the wrong setting. This project will be limited to a representative sample of 380 hospitals nationwide that volunteer to be part of the program.[\[10\]](#)

The Prepayment Review Demonstration Project: Shifting Away from RAC Methodology?

Although CMS has released only limited formal guidance, it has gradually shared certain facts and parameters regarding the prepayment review demonstration project. The project will focus its efforts in 11 states. Seven of these states were selected because they reportedly have significant populations of fraud- and error-prone providers (California, Florida, Illinois, Louisiana, Michigan, New York, and Texas). The other four states were selected for having relatively high claims volumes of short inpatient hospital ("one day") stays (Missouri, North Carolina, Ohio, and Pennsylvania). The project will last from summer 2012 through December 31, 2014.

Through the demonstration project, RACs will take a new posture: reviewing selected claims to determine whether the provider has complied with all relevant Medicare payment rules *before* Medicare makes a payment to the provider or supplier. In other words, RACs will be able to select claims and request medical record documentation before the MACs are allowed to pay them.

CMS shared some additional details about the project during a December 2011 Special Open Door Forum call. Most notably, CMS repeatedly made the point that it has attempted to keep the process for the demonstration project as consistent as possible with the current process for prepayment review by MACs. All facilities that are physically located in, and that bill to the Fiscal Intermediary (FI) or MAC within, the 11 states will be subject to the demonstration project. The demonstration project is not intended to replace the ongoing prepayment review conducted by FIs or MACs; instead, it is intended to be a separate effort that focuses on lowering error rates. Further, CMS stated that the agency is encouraging collaboration between contractors, so that providers are not subject to review for the same topic or issue by two different contractors. Additional documentation requests will come to providers from the FI or MAC and will contain details regarding where providers should submit documentation. As with the current MAC prepayment review process, providers will have 30 days to submit the requested documentation. A claim will automatically be denied if such documentation is not received within 45 days. Once the RAC receives the documentation, it will review the claim and communicate a payment determination back to the FI or MAC. Providers will receive news regarding the payment determination on the remittance advice, within 45 days. The RACs also will send detailed review results letters.[\[11\]](#)

During the Special Open Door Forum call, CMS also clarified certain operational details regarding the demonstration project. According to CMS, the limits on prepayment review will not exceed current post-payment additional documentation request limits.[\[12\]](#) For claims denied through prepayment review, providers will have the right to appeal the denials and will have the same appeal rights as they do with other types of denials. If a claim is denied for non-receipt of medical records, any medical records provided during an appeal to a FI or MAC will be remanded to the RAC for review. Finally, CMS stated that claims reviewed as part of the demonstration project will be "off-limits" from future post-payment reviews from MACs and RACs.[\[13\]](#)

Although CMS has provided only limited educational materials as guidance regarding this new program, providers should consider that the Medicare Program Integrity Manual provides a helpful framework for how prepayment review would apply to the RACs.[\[14\]](#)

During the Special Open Door Forum call, CMS also announced the initial list of diagnosis related groups (DRGs) eligible for prepayment review through the demonstration project.[\[15\]](#) A spokesperson for the agency explained that this list was developed from review of analytics in a 2010 CERT report.[\[16\]](#) In this report, CMS identified short hospital stays as a problematic area. Specifically, problems arose due to incorrectly coded claims, patients who came through the emergency department but who should have subsequently gone to observation rather than being admitted, and patients who received elective surgery during short-day stays when they should have been outpatient procedures.[\[17\]](#) CMS selected the initial DRGs for the prepayment review demonstration project based on the analysis in the 2010 CERT report. According to the agency, these particular DRGs are problematic across the country.[\[18\]](#)

CMS has not offered insight into the amount of resources to be committed to prepayment reviews by RACs, such as the percentage of cases to be evaluated, the complexity of the reviews to be performed, or the timing for the reviews (versus the current RAC practice of post-payment reviews). It is thought that the demonstration project may at some point focus, in part, on physician billing patterns. As such, physicians associated with hospitals may start to see an uptick in requests, as the RACs look for errors at the physician level and the facility level.

It is also likely that CMS is keeping a close eye on similar efforts, particularly those at the state level, while establishing the criteria and process for the demonstration project. Examples of monitoring programs that are seeing successful results are, from CMS' perspective, likely useful models for further development of prepayment review. There is, for example, an effort underway currently by First Coast Service Options (FSCO), a Florida Medicare Administrative Contractor that began conducting prepayment review for 100% of 25 DRGs in March 2012.[\[19\]](#) Through these reviews, FSCO committed to

recouping physician fees for medically unnecessary services identified through the course of the prepayment review.

Providers . . . Be Reactive, Responsive, and Prepared!

To minimize the impact of responding to RAC audit requests, providers and suppliers should consider taking certain steps to assess, analyze, and, as necessary, improve internal auditing and monitoring policies, procedures, and processes. Through current RAC methodology, a hospital can receive up to 400 requests for medical records every 45 days for post-payment RAC review.^[20] Through the prepayment review demonstration project, a hospital will be eligible to receive an additional 400 requests for medical records every 45 days for prepayment RAC review. The pressure placed on organizations having to respond to both post-payment and prepayment RAC audit requests may raise issues related to staffing, budgeting, and an organization's internal process for coordinating responses to RAC requests and managing appeals. Thus, as providers take time to evaluate professional and organizational practices, having and following a checklist may be helpful:

1. *Stay Current.* It is important for all providers to stay current with relevant materials posted by MACs, RACs, CERTs, Zone Program Integrity Contractors, and the Office of Inspector General, as these entities often produce reports for CMS that are good sources of compliance monitoring. These contractors may identify new risk areas as their audits expand. Organizations should continuously assess whether their compliance program is appropriately responsive to new risk areas as they are identified and to any noteworthy trends in enforcement activities.
2. *Consider Staging a Mock Audit.* In anticipation of the demonstration project, some organizations are staging mock audits with a specific focus on the DRGs that may be the initial focus of the project. When planning for a mock audit, consideration should be given to auditing various operational functions, such as billing, coding, and documentation. Any errors identified through the mock audit process should be corrected in a timely manner. Although a mock audit can be a significant undertaking for an organization, the effort allows the organization to develop its own, specific internal benchmarks for an error rate, which not only will allow the organization to ensure compliance for the specific DRGs examined but also will help the organization stay, as best as possible, ahead of the RAC curve.
3. *Document, Document, Document.* Organizations should examine current policies and practices around medical record documentation, including a review of templates that may be outdated or may lack the sophistication that CMS is now looking for to substantiate billed services. If needed, organizations should consider implementing documentation requirements around the issue of whether patient treatment meets the relevant LCD and/or national coverage determination guidelines. An organization should have a RAC "gatekeeper" for documentation purposes to ensure the production of consistent, complete, accurate, and appropriately responsive documentation when responding to RAC requests.
4. *Do Not Underestimate the Power of Education.* In connection with examining documentation policies and practices, organizations should also evaluate the

education and training functions currently in place to understand whether improvements should be made to reflect the changing RAC landscape. An upfront investment in educating and training an organization's clinicians (e.g., medical staff, employed or contracted physicians, nurses, physical therapists, medical directors) on documentation and billing requirements is critical, as they are the "front lines" for documenting treatment plans and medical necessity. It is as important for clinicians to understand the impact of medical record documentation as it is for the individuals who are doing the actual coding and billing. An organization also stands to benefit significantly from a strong case management function and an active utilization review committee.

5. *Coordinate the Response.* A coordinated response to a RAC request for medical records will undoubtedly enable an organization to put its best foot forward. Every organization needs to determine what process works best given the dynamics and culture of the organization; however, a process of some kind must exist or mistakes will be made. A methodical process for responding to RAC requests will help an organization produce legible, organized, responsive, and timely documents to the RAC. Organizations should consider designating at least one person (or more, depending on the size of the organization and historical RAC volume) to interface with the RAC. This will help an organization respond with "one voice."
6. *Understand Your Appeal Rights and Be Strategic.* While the appeal process will likely track the current Medicare claims appeal process, it will be important to carefully examine the denial letters that providers begin to receive as a result of actual RAC prepayment audits taking place. However, organizations should carefully evaluate the appeal process, paying particular attention to the many deadlines that are imposed on providers throughout the appeal. Organizations should create a tracking mechanism to manage appeals and consult with internal or outside advisors to ensure that all elements of the appeal process are addressed thoroughly. In addition, it may be helpful to discuss the strategic value of appealing certain denials that, on their face, may be too time-consuming and expensive, in light of what appears to be a relatively low dollar amount of denied claims.
7. *Keep Leadership in the Loop.* An organization's process for managing RAC requests should incorporate regular reporting to the organization's senior management and/or board of directors. It is critically important for an organization's leadership to understand, at least at a high level, how and how often the organization is responding to such requests. An organization may need to grow its compliance function as these types of auditing practices evolve. Further, an organization's leadership must be "in the know" in order to support and, if needed, enhance the resources needed to respond to RAC requests.
8. *Plan for the Future.* Organizations should take steps to implement appropriate financial planning that considers the potential impact of prepayment review by the RACs. Some providers have suggested that prepayment audits will cause particular strain on their business because their standard practice is to suspend payments for services unless and until claims are approved. Depending on the size of the organization, financial planning may require input from various business units and/or senior management to understand the current financial state of the organization, in order to project how a prepayment RAC audit could put pressure on the organization's cash flow.

As the RAC model begins to shift, providers will need to respond with equal vigilance in order to proactively ensure compliance and to be in a better position to effectively respond to audit requests. The prepayment review demonstration project may create significant challenges for providers by virtue of the fact that prepayment review allows RAC auditors to deny payment upfront and force providers to go through the Medicare claims appeal process to obtain any payment, which can be a significant challenge in terms of restricted resources and cash flow.

While the actual impact of the prepayment review demonstration project has yet to be seen, the current auditing and monitoring climate suggests that providers must make the investment now in time and energy to ensure that claims meet applicable payment requirements and that, more importantly, an organization stands ready to respond when the RACs come knocking.

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[1] Centers for Medicare & Medicaid Services, Fact Sheet, "CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments," *available [here](#)* (Nov. 15, 2011).

[2] Pub. L. No. 108-173 (2003). *See also* Centers for Medicare & Medicaid Services, Recovery Audit Program, Historical Background, *available [here](#)* (last modified Mar. 10, 2012).

[3] Pub. L. No. 109-432 (2006).

[4] Centers for Medicare & Medicaid Services, "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" (Oct. 2011), *available [here](#)*. In FY 2010, 82% of all RAC program corrections were collected overpayments and 18% were identified underpayments that were refunded to providers. *Id.* at v.

[5] Centers for Medicare & Medicaid Services, *Medicare Fee for Service National Recovery Audit Program, Quarterly Newsletter (Jan. 1, 2012 – Mar. 31, 2012)*, *available [here](#)*.

[6] The Region A RAC is Diversified Collection Services, Inc.; the Region B RAC is CGI Technologies and Solutions, Inc.; the Region C RAC is Connolly Consulting Associates, Inc. (Connolly); and the Region D RAC is HealthDataInsights, Inc.

[7] *See* Epstein Becker Green Client Alerts, "CMS Publishes Solicitation for Industry Comment on RAC Program Expansion to Medicare Part C and Part D: Plans and Their Contracted Providers Should Consider Submitting Comments by 2/25/11 Deadline," *available [here](#)* (Jan. 20, 2011), and "RAC Roundup: What's on the Horizon for Medicare Part C and D RACs? Medicaid RAC Implementation is Underway," *available [here](#)* (Mar. 15, 2012).

[8] Press Release on The Affordable Care Act: Strengthening Medicare, Combating Misinformation and Protecting America's Senior (June 8, 2010), *available [here](#)*.

[9] Press Release on President Obama to Sign Improper Payments Elimination and Recovery Act (July 22, 2010), *available [here](#)*.

[10] Centers for Medicare & Medicaid Services, Fact Sheet, "CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments," *available [here](#)* (Nov. 15, 2011).

[11] Transcript of Centers for Medicare & Medicaid Services, Special Open Door Forum: Medicare Fee-for-Service Recovery Auditor Prepayment Review Demonstration (Dec. 21, 2011), *available [here](#)*.

[12] See Centers for Medicare & Medicaid Services, "Medicare Fee-for-Service Recovery Audit Program: Additional Documentation Limits for Medicare Providers (except suppliers and physicians)" (Mar. 12, 2012), *available [here](#)*. Additional documentation request limits are calculated according to the following parameters: (a) the maximum request amount is per "campus" (defined to mean one or more facilities under the same Tax Identification Number (TIN) located in the same area, using the first three positions of the ZIP code); (b) each limit is based on the provider's prior calendar year Medicare claims volume; (c) the limit is based on claims volume only (the types of claims do not factor into the limit); (d) the maximum number of requests per 45 days is 400; (e) RACs may request up to 35 records per 45 days from providers whose calculated limit is 34 additional documentation requests or less; (f) the limit is equal to 2% of all claims submitted for the previous calendar year divided by eight. The RACs may go more than 45 days between record requests but may not make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services; (g) for skilled nursing facility claims, one additional documentation request represents a beneficiary's entire episode of care (this includes medical records for all services rendered from the date of admission to the final date of discharge); and (h) CMS may give the RACs permission to exceed the limit, either by CMS' own initiative or from the RAC requesting permission. CMS or the RAC will notify affected providers in writing. *Id.*

[13] Transcript of Centers for Medicare & Medicaid Services, Special Open Door Forum: Medicare Fee-for-Service Recovery Auditor Prepayment Review Demonstration (Dec. 21, 2011), *available [here](#)*.

[14] Chapter 3 of the Medicare Program Integrity Manual outlines rules for prepayment review of claims that would apply to the RACs.

[15] The list of DRGs that will be the initial focus of the prepayment review demonstration project is as follows: January 1: 312 (Syncope & Collapse); March 1: 069 (Transient Ischemia) and 377 (G.I. Hemorrhage w/MCC); May 1: 378 (G.I. Hemorrhage w/CC) and 379 (G.I. Hemorrhage w/o CC/MCC); July 1: 637 (Diabetes w/MCC), 638 (Diabetes w/CC), and 639 (Diabetes w/o CC/MCC). Centers for Medicare & Medicaid

Services, Recovery Auditor Prepayment Review Demonstration (Dec. 19, 2011), *available [here](#)*.

[16] Centers for Medicare & Medicaid Services, Medicare Fee-for-Service 2010 Improper Payment Report (Nov. 2011), *available [here](#)*. CMS implemented the CERT program to measure improper payments in the Medicare fee-for-service (FFS) program. The CERT program was designed to comply with the IPERA. According to CMS, the CERT program cannot be considered a measure of fraud, since the CERT program uses random samples to select claims and reviewers often are unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent. All public reports produced by the CERT program are available on the CMS website. See Centers for Medicare & Medicaid Services, Comprehensive Error Rate Testing, *available [here](#)* (last modified May 15, 2012).

[17] Centers for Medicare & Medicaid Services, Medicare Fee-for-Service 2010 Improper Payment Report (Nov. 2011), *available [here](#)*.

[18] Transcript of Centers for Medicare & Medicaid Services, Special Open Door Forum: Medicare Fee-for-Service Recovery Auditor Prepayment Review Demonstration (Dec. 21, 2011), *available [here](#)*.

[19] First Coast Service Options, Inc., Improper Payments and Inpatient Prepayment Medical Review—Update, *available [here](#)* (Mar. 12, 2012); *see also* American Medical Association, "Medicare Intensifying Documentation Reviews Before Payment," *available [here](#)* (Jan. 16, 2012). The focus of the FSCO efforts is primarily on cardiovascular and orthopedic services.

[20] Centers for Medicare & Medicaid Services, "Medicare Fee-for-Service Recovery Audit Program: Additional Documentation Limits for Medicare Providers (except suppliers and physicians)" (Mar. 12, 2012), *available* [here](#). These increased RAC record request limits for hospitals became effective on March 15, 2012. Under the new rule, the limit is 2% of all Medicare claims (of all types, including professional services) submitted for the previous calendar year divided by eight, up to a maximum of 400 requests every 45 days. For small providers that otherwise would have a calculated limit of 34 records or less, Connolly may request up to 35 records every 45 days. This is an increase from the previous 1% limit. The limits apply per "campus," which, as previously noted, is defined as one or more facilities under the same TIN located in the same area, using the first three positions of the ZIP code. CMS states that this is a different definition than the one used to determine provider-based status. *Id.*

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