

# PHYSICIAN ADVISORY SERVICES

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*If there are topics you would like to see addressed in future issues, please email your ideas to:*

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## IT'S NOT JUST ABOUT RACs

The CMS regulations that control how hospitals are required to bill for services rendered to patients can be cumbersome and confusing for health care professionals desiring to have policies and procedures in effect that are in compliance with the regulations. It is some comfort to know that all entities that investigate and enforce CMS regulations follow the same regulations. Some of the entities that are in the "alphabet soup" of enforcers include:

- Recovery Audit Contractors (**RACs**)
- Department of Justice (**DOJ**)
- Office of Inspector General (**OIG**)
- Fiscal Intermediaries (**FIs**)
- Medicare Administrative Contractors (**MACs**)
- Medicaid Integrity Contractors (**MICs**)

Program Safeguard Contractors (**PSCs**)

Zone Program Integrity Contractors (**ZPICs**)

It is not a comfort, however, that the "non-RAC" entities can be less "kind" than the RACs. In the February 2010 OIG report entitled Recovery Audit Contractors' Fraud Referrals, it states that "RACs are not responsible for reviewing claims for fraudulent activity. CMS contracts with PSCs and ZPICs to perform benefit integrity functions including fraud detection. However, in the course of reviewing claims for improper payments, RACs may come across instances where the overpayment appears to involve fraudulent activity. RACs are responsible for referring these instances of potential fraud to CMS." Since during the demonstration project RACs referred only two cases of poten-

tial fraud to CMS during the demonstration project, the OIG is concerned that the RAC staff members are not knowledgeable about fraud, are not trained to identify fraud cases and, therefore, are not equipped to carry out the detection duty. The OIG made the following three recommendations to CMS:

- Conduct follow-up to determine the outcomes of the two referrals made during the demonstration project.
  - Implement a database system to track fraud referrals.
  - Require RACs to receive mandatory training on the identification and referral of fraud."
- CMS has responded to the OIG that they concur with the three recommendations and the OIG training session on the identification of fraud was scheduled in January, 2010.

## HOT ISSUE: BALANCING THE CMS GUIDANCE

In developing and implementing a strong compliance plan that allows hospitals to work comfortably within the regulations, hospitals often try to develop policies and procedures that assist them in determining whether a patient is receiving inpatient or observation services based on CMS guidance. Although hospitals may start with the Medicare Benefit Manual, Chapter 1, they can find themselves searching through the Quality Improvement Organization (QIO) Manual, and the Program Integrity Manual (PIM) which quickly refers them back to the Medicare Benefit

Manual. The search can result in making one feel that there is no clear guidance. In going back and forth between the different regulatory guidance, hospitals need to understand that the factors work together and must be balanced in order for appropriate decisions to be made. For example, the QIO Manual states when a physician reviewer is reviewing a case for medical necessity the reviewer, when examining the medical record must consider any preexisting medical problems or extenuating circumstances that make admission of the patient medically nec-

essary. Factors that may result in an inconvenience to a patient or family do not, by themselves, justify inpatient admission. When such factors affect the patient's health, consider them in determining whether inpatient hospitalization was appropriate. One can surmise that these factors in and of themselves are not sufficient but can be used with other factors to support medical necessity. For additional information, please contact Ann Purdy at 205-314-8859 or email her at [apurdy@medmanagementllc.com](mailto:apurdy@medmanagementllc.com)

## RAC FAQs - EXCERPTS FROM CMS WEBSITE

### Region A-DCS

<http://www.dcsrac.com/issues.html>

### Region B-CGI

<http://racb.cgi.com/Issues.aspx?st=1>

### Region C-Connolly Healthcare

[http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)

### Region D-HCI

<https://racinfo.healthdatainsights.com/Public/NewIssues.aspx>

### To access the other RAC FAQs on the CMS website visit :

[http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?pv=4.497](http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?pv=4.497)



### **Why is CMS using recovery audit contractors?**

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required CMS to complete a demonstration project to demonstrate the use of recovery audit contractors in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under Part A or B of title XVII of the Social Security Act. The demonstration operated from March 2005 through March 27, 2008. Section 302 of the Tax Relief and Health Care Act of 2006 (TRAHCA) required the Department of Health and Human Services (DHHS) to

make the RAC program permanent and nationwide by 2010. CMS is planning a gradual expansion to all 50 states. The expansion schedule can be viewed at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC).

### **Under what circumstances will a RAC request medical records in order to determine if an overpayment exists?**

RACs must use complex review (where medical records ARE involved in the review) in situations where there is a high probability (but not certainty) that the claim contains an overpayment.

### **Will Recovery Audit Contractors review evaluation and management (E&M) services on physician claims under Part B?**

Yes, the review of all E&M services will be allowed under the RAC program. The review of duplicate claims or E&M services that should be included in a global surgery were available for review during the RAC demonstration and will continue to be available for review. The review of the level of the visit of some E&M services was not included in the RAC demonstration. CMS will work closely with the American Medical Association and the physician community prior to any reviews being completed regarding the level of the visit and will provide notice to the physician community before the RACs are allowed to begin reviews of E&M services and the level of the visit.

## WHAT IS URAC AND WHY SHOULD I CARE?

In 2008, MedManagement received a three year accreditation for Health Utilization Management from URAC. The decision to go through the process was one that the leadership team at MedManagement thought was important for the organization to move forward in providing concurrent reviews for hospitals.

In 1990, URAC developed the first Health Utilization Standards to ensure that organizations conducting utilization review followed a process that was clinically sound and respected patients' and providers' rights while giving payors reasonable guidelines to follow.

Today URAC is the leader in Utilization Management Accreditation and Certification. Since creating its first standards that set the bar for health utilization review, URAC has continued to create and revise the standards that have transformed the industry.

The Utilization Management

standards build on the core accreditation standards, and:

- Establish consistency and maintain the highest confidentiality in UM processes

- Serve as the basis for many states' laws and regulations and are the most widely recognized UM standards at the state and federal level

- Are applicable to stand-alone UM organizations and UM functions within health benefits programs such as indemnity insurance, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and the newer Consumer-Directed Health Care plans.

- Can be adopted by specialty UM companies, such as behavioral health and CAM

- Are compatible with the 2002 U.S. Department of Labor claims regulations

"MedManagement is honored to receive Health Utilization Management Accreditation from URAC," said Joan Ragsdale. "We are very pleased to be recognized in the industry for providing outstanding services. Such a distinction also underscores the quality of our work with customers, patients, clients, payors, and providers by demonstrating compliance with national standards for utilization management processes."

For more information please contact Carol Coley, MedManagement's Compliance Officer at 205-314-8851 or email her at [ccoley@medmanagementllc.com](mailto:ccoley@medmanagementllc.com).