

PHYSICIAN ADVISOR SERVICES

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2012: NEW YEAR AND NEW CMS ACTIVITY

By January 3, 2012 responsibility for issuing Recovery Auditor (RAC) overpayment demand letters (recoupment letters) will be moved from the RACs to CMS claims processing contractors. In our September 2011 newsletter we shared the notification of this change with you. Discussion on this change can be found in MLN Matters Number MM7436. The change is important to providers because the processes structured to work with the RAC will have to be redesigned. A critical issue is the ability of the facility to make certain these recoupment letters are identified as recoupment letters and are directed to the appropriate person.

There is a real concern that the letters will not be addressed to the designated contact person as reported by each hospital in its information submitted to the Recovery Auditors. The correspondence will now be directed to the person at each hospital whose name is associated with the hospital's provider number. As

you know, the person whose name is connected to the provider number could be a person who is no longer associated with your facility. The procedures hospitals established to address RAC correspondence need to be modified to ensure that letters sent by claims processing contractors are identified as recoupment letters and given to the appropriate parties. Although this change was made (according to CMS) to avoid any delays in demand letter issuance, by changing the party receiving the notifications, facilities could experience difficulty in identifying the nature of the letter and responding timely. Our advice is to find out who is receiving correspondence from the claims processing contractors and establish a procedure for getting the demand letters associated with the Recovery Auditors to the person responsible for timely response.

Another update on an item we discussed in our December newsletter has to do with the three demonstration projects CMS an-

nounced on November 15, 2011. As a reminder the purpose of the demonstration projects "is to strengthen Medicare by aiming at eliminating fraud, waste, and abuse." Of the three projects all but one has been delayed until further notice. The **Part A and Part B Rebilling** is the project that still **begins** on January 1, 2012.

In response to the many comments and suggestions CMS received in response to the **Prior Authorization of Power Mobility Devices (PMD) and Recovery Audit Prepayment Review projects**, it determined that a delay in the implementation would allow for the comments to be carefully considered. At least a 30 day notice will be given before the demonstrations begin. The CMS update related to the demonstration projects can be accessed by clicking [here](#).

For additional information, please contact Ann Purdy at 205-314-8859 or by clicking [here](#).



Medicare Fee-for-Service Recovery Audit Program FY 2011

Recovery Audit National Program— Fiscal Year 2011

	FY 2011 Oct 2010– Dec 2010	FY 2011 Jan 2011– Mar 2011	FY 2011 Apr 2011– Jun 2011	FY 2011 Jul 2011– Sep 2011	Total National Program Oct 2010– Sept 2011
Overpayments Collected	\$82.9M	\$187.4M	\$250.0M	\$277.1M	\$797.4M
Underpayments Returned	\$9.6M	\$14.8M	\$41.0M	\$76.6M	\$141.9M
Total Corrections	\$92.4M	\$202.2M	\$291.0M	\$353.7M	\$939.4M
*FY 2010 Total Corrections: \$92.3M Overpayments Collected: \$75.4 M Underpayments Returned: \$16.9M					
**All figures are provided in millions					

Top Issue per Recovery Auditor (July—September 2011)

Region A: Diversified Collection Services	Renal and Urinary Tract Disorders (Medical Necessity Review): Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with renal and urinary tract disorders needs to be complete and support all services provided.
Region B: CGI, Inc.	Surgical Cardiovascular Procedures — Collaborative (Medical Necessity Review): Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with surgical cardiovascular procedures needs to be complete and support all services provided.
Region C: Connolly, Inc.	Acute Inpatient Admission Neurological Disorders – Collaborative (Medical Necessity Review): Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with acute inpatient admissions for neurological disorders needs to be complete and support all services provided.
Region D: HealthDataInsights	Minor Surgery and Other Treatment Billed as an Inpatient Stay (Medical Necessity Review): When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

Region A-DCS

<http://www.dcsrac.com/IssuesUnderReview.aspx>

1-866-201-0580

Region B-CGI

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

1-877-316-7222

Region C-Connolly Healthcare

http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

1-866-360-2507

Region D-HDI

<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>

866-590-5598 (Part A)

866-376-2319 (Part B)

RAC FAQs - EXCERPTS FROM CMS WEBSITE

What is the reimbursement procedure and rate for photocopy charges associated with records for Recovery Audit Contractors (RAC) audits? RACs are required to reimburse PPS providers and Long Term Care providers. The reimbursement rate is 12 cents per page for reproduction of medical records. Facilities are not required to submit vouchers to the RAC requesting payment. Rather, the RACs will automatically issue payments to the hospitals for photocopying charges. RACs are required to pay for

copying on a monthly basis. All checks should be issued within 45 days of receiving the medical record.

What specific information does the provider community need to submit when responding to a Recovery Auditor's Additional Documentation Request Letter? RAC Additional Documentation Request Letters specifically indicate suggested medical documentation that providers should submit in order to justify the services billed.

Are providers required to submit all the suggested documentation (including physician queries) identified in the Additional Documentation Request Letter they receive from Recovery Auditors?

CMS requires that providers include the appropriate documents that justify the services billed. This may require that a provider include the entire medical record including physician queries.

To view all of the CMS RAC FAQs, click [here](#).