

# PHYSICIAN ADVISOR SERVICES

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## CMS ISSUES MEDICAID RAC FINAL RULE

On September 14, 2011 the long awaited state Medicaid Recovery Audit Contractor (RAC) final rule was issued. Under the final rule, states must have Medicaid RAC programs in place by January 1, 2012.

Providers should not confuse the Medicaid RACs with the Medicaid Integrity Contractors (MICs). The MICs are part of the Medicaid anti-fraud initiative called the Medicaid Integrity Program (MIP). The MIP is the federal government's first real attempt at scrutiny of the state run Medicaid programs. The MIP's focus is eliminating fraud and abuse in the Medicaid program which is perceived to have a high error rate.

As with the Medicare RACs, the Medicaid RACs are private companies paid on a contingency fee basis. The focus is to identify Medicaid underpayments and overpayments and recoup the overpayments.

Since the Medicaid RAC development drew from the history of the establishment of the Medicare RAC program there was great concern from providers. When the final rule was published about 70% of the document was dedicated to responding to the public's comments.

Commenters were concerned about the duplication of efforts from the many auditing entities. Several commenters were concerned that

the overbearing environment could impact provider participation and ultimately patients' access to care. The response to the concerns stated, "continuation of existing program integrity activities is important to ensure a comprehensive State program integrity program that includes more than a claims auditing program such as the Medicaid RAC program. Other critical components of a Medicaid integrity program include Surveillance and Utilization Review unit activities, MMIS system monitoring, and fraud prevention and detection activities." The response goes on to state, "while RACs are an efficient way to identify payment errors, they are not the most effective approach to identify or prevent fraudulent practices. Federal MICs can focus on audit issues that may be less advantageous for a contingency-fee based contractor."

The use of contingency fees for the Medicaid RACs continues to be a concern of providers. One commenter stated that the contingency fee schedule is inappropriate because it "perversely incentivizes RACs to engage in bounty hunting, which leads to increased expenses and administrative burdens for providers." Because a large number of the Medicare RACs' payment denials were overturned on appeal, the concern appears to be warranted.

However, the statute requires that the Medicaid RACs be paid on a contingency fee basis and neither CMS nor the states can change this methodology unless state law prohibits the arrangement.

So, RACs are here to stay and expanding. The best defense against Medicaid RAC denials and recoupment is the same as for the Medicare RACs...clear and complete documentation. Medical records must document that the services are medically necessary and in the most appropriate level of care.

Medicaid compliance should be an important initiative for each provider. As with Medicare compliance, a provider should do all it can to assure that CMS regulations and guidance are followed. However, the subjectivity of some of the regulations can cause differences in interpretation, especially when review entities are paid on a contingency fee basis.

As you are reviewing your procedures for documenting medical necessity and appropriate level of care, let us know if we can provide assistance.

Click [here](#) to be linked to the final ruling in the Federal Register.

For more information about this article, contact Ann Purdy by clicking [here](#) or call her at 205-314-8859.

## RECOVERY AUDIT PROGRAM STATEMENT OF WORK - REVISED

On September 12, 2011 The Centers for Medicare & Medicaid Services (CMS) released a revised Statement of Work (SOW) for the Recovery Audit Program. Some subtle changes are found in the release along with new statements of which providers should be aware.

One item of interest is the fact that the Recovery Audit Contractor program is now referred to as the Recovery Audit Program with "Contractor" being removed from the title. This is not a substantive change but an interesting change none the less. In the revised SOW references to RAC are now referenced as Recovery Auditors.

Providers may find the guidance relating to the discussion period of interest. The revised SOW states, "(I)f during the discussion period the recovery auditor is notified by the contractor that the provider initiated the appeals process, the recovery auditor shall immediately discontinue the discus-

sion period and send a letter to the provider that the recovery auditor cannot continue the discussion period once an appeal has been filed." Therefore, this requires providers to make a decision rather than initiating discussion and filing an appeal during the same period of time. The discussion period may not be as attractive because the ability to file an appeal and stop the recoupment may be delayed.

In the SOW there is a section dedicated to semi-automated reviews. Although the recovery auditors have been using semi-automated reviews the SOW now defines these reviews as a specific form of claims review along with automated review and complex review. The definition of a semi-automated review is:

*"Semi-Automated Review is a two-part review. The first part is the identification of a billing aberrancy through an automated review using claims data. This aberrancy has high index-*

*es of suspicion to be an improper payment. The second part includes a Notification Letter that is sent to the provider explaining the potential billing error that is identified."*

Another section that was expanded in the revised SOW pertains to extrapolation. It states, "(R)ecovery auditors are encouraged to use extrapolation for some claim types when all requirements are met. Extrapolation may be cost effective for low dollar claims that require complex review that have a history of having a high error rate." Although extrapolation was in the previous SOW the new language in the revised SOW clearly supports the use of extrapolation.

The link to the left will take you to the SOW. Additional clarifications are presented in the document.

If you have any questions, please contact Ann Purdy at 205-314-8859 or email her by clicking [here](#).

Here is the link to the Recovery Audit Program Statement of Work:

<https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf>

### 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](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

### **Can the Recovery Auditors do a medical necessity review on a claim that they originally reviewed for DRG validation?**

Beginning November 1, 2010 if the RAC has already requested documentation and issued a review results letter to the provider for a DRG validation, the RAC will be allowed to re-review the claim again for medical necessity. However, if both issues are approved (DRG Validation and medical necessity) prior to the request of the addi-

tional documentation, the RAC may also conduct both reviews simultaneously. Each additional documentation request (ADR) is subject to the same review timeframes and counts toward the provider's ADR limit.

**Will Code N432 appear on the remittance advice for Recovery Audit Contractors (RAC) adjusted claims?** CMS created code N432 to identify RAC adjusted claims, however CMS believes the code is being su-

perseded in some of the systems by code N469 which is the Section 935 Limitation on Recoupment code. We are working to correct this problem in the system. Providers will receive demand letters for all RAC adjusted claims. These letters will allow providers to keep track of RAC adjustments versus all other claims processing adjustments.

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

## DR. PALEGA TO SPEAK IN LAS VEGAS IN OCTOBER

Dr. Gregory Palega is scheduled to speak in Las Vegas at the 17th Annual Case Management Along the Continuum conference being held October 9-12, 2011. On Sunday, October 9th, he will speak along with Deborah Hale, President and CEO of ACS, LLC, on the

subject of "Inpatient Admission Versus Outpatient Services: A Guide to Compliant Level of Care Determinations". On Monday, October 10th his topic is "Handling Department of Justice Fraud Investigations" followed on Tuesday, October 11th by a session

titled "The Truth About Medicare Levels of Care: Inpatient vs. Observation Rules".

MedManagement will be exhibiting at the conference so please stop by and visit if you are attending.



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