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Prepare your practice for a visit from the RACs

As if hospitals and physician practices don't have to jump through enough government-mandated hoops, CMS is throwing yet another obstacle into their path by expanding the use of recovery audit contractors (RAC)—private firms that audit the claims of providers that participate in FFS Medicare, including hospitals, skilled nursing facilities (SNF), physicians, durable medical equipment suppliers, and labs.

RACs receive carte blanche from CMS to rifle through paid claims for a controversial incentive: They receive a negotiated contingency fee—a percentage of the overpayments they identify that providers are required to repay. Although they're required to identify underpayments as well, it's clear their mission is geared toward finding overpayments.

A three-year RAC demonstration project will begin transitioning to a permanent program this year. Twenty states came under RAC scrutiny in March, with a handful more joining them in October and the remainder scheduled for 2009. And although most of the RAC audits during the demonstration program focused on inpatient hospitals and SNFs, CMS is hiring more Part B auditors to look at physicians and suppliers.

Hospitals and physician practices need to incorporate RAC guidelines into their coding and billing compliance plans because the cost of noncompliance could be enormous, sources tell **MCCRA.** Fortunately, providers have an opportunity to get things right on the front end, as the initial lookback period for potential overpayments is limited to just six months of Medicare FFS claims.

> **"Many well-written compliance plans just sit on the shelf, and that doesn't do your practice any good."**
>
> *—David C. Harlow, Esq.*

"This is a serious compliance concern," says **Michael G. Apolskis,** an attorney at MacKelvie & Associates, PC, in Chicago. The contingency compensation for RACs may make them overzealous, he says, so the first year that a RAC enters a new jurisdiction is a critical time for all providers. Eventually, providers that don't understand Medicare policy or that apply it improperly could face enormous exposure.

Use lookback period to your advantage

CMS has divided the United States into four geographic regions, with a single RAC performing the recovery audits for all types of Medicare claims in each region.

RACs may attempt to identify improper payments resulting from:

- Incorrect payment amounts, except when CMS directs contractors otherwise
- Noncovered services, including services that are not reasonably necessary

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RACs

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- Incorrectly coded services, including DRG miscoding
- Duplicate services

RACs may only attempt to identify improper payments arising from services provided under FFS Medicare, Apolskis says. They may not address the cost report settlement process, claims more than three years past the initial determination (claim paid) date or paid before October 1, 2007, claims in which the provider is without fault, and claims with special processing numbers such as Medicare demonstrations.

RACs are precluded from reviewing E/M services on Part B physician claims unless the E/M claims cover services that are not "reasonable and necessary." However, RACs can examine violations of Medicare's global surgery payment rules in cases involving E/M services, and they can review E/M services on outpatient hospital claims.

The lookback period is an important ally to providers this year. Because RACs may not review claims with paid dates earlier than October 1, 2007, "even providers that have not yet implemented Medicare coding and billing compliance programs have limited exposure," says **David C. Harlow, Esq.,** principal at The Harlow Group, LLC, in Newton, MA. Providers should fine-tune their compliance programs quickly, because the lookback period will gradually extend to three years. For example, RACs will have the authority to audit claims with October 2007 paid dates until October 2010.

Examine claims that could be vulnerable

Knowing the likelihood that a RAC will knock on your door and the types of claims it might review would be enormously helpful, but CMS has shrouded those questions in mystery. The original Statement of Work included timetables by provider type and state, but in November 2007, CMS removed any references to providers. "Now it's just a state-by-state implementation," Apolskis says.

That being said, a 2007 RAC status document released in February by CMS suggests that RAC audits are likely to be widespread and target provider organizations with large Medicare claims—especially hospitals, SNFs, and physician groups with high-cost or high-volume procedures and services. CMS supplies RACs with a data file containing claims histories, followed by monthly updates, Apolskis says. RACs then use proprietary software and their knowledge of Medicare rules and regulations to determine which entities to review. The 2007 status document indicates that some RACs used OIG and General Accounting Office reports to identify claims that were likely to have improper payments, so these reports also may help providers identify vulnerabilities, Apolskis says.

RACs can analyze your claims using two methods. During an automated review, a RAC makes a claim determination at the system level without reviewing

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the medical record. Automated review must be guided by a clear written policy—a statute, regulation, or national or local coverage decision that specifies the circumstances under which a service will always be considered an overpayment. But automated review also must be based on a medically credible service, so a RAC may examine claims in which it's certain that medical necessity or coding rules were violated but no explicit policy or guideline exists, Apolskis says. They also may use automated review for other determinations, such as duplicate claim determinations, that meet the certainty threshold for improper payment.

Complex review involves the medical record. In the absence of written policy, RACs are supposed to use appropriate medical literature and apply clinical judgment, and their medical directors are supposed to be actively involved in examining the medical evidence. Similarly, RACs are required to have RNs or therapists make coverage and medical necessity determinations and have certified coders make coding determinations.

CMS may limit the number of medical records that RACs request for complex reviews, Apolskis says. For hospitals, the limit may be based on the number of beds—for example, no more than 50 inpatient medical record requests in a 45-day period for a hospital with 150–249 beds. Moreover, RACs may not bunch medical record requests. If the limit for a particular provider is 50 records per month and a RAC doesn't request any in January and February, the RAC cannot request 150 records in March, Apolskis says.

Medical record requests could become especially onerous for physician practices. Although RACs are required to pay for medical records associated with acute and long-term care hospital claims, they are not required to pay for those associated with other types of claims, including physicians. Providers have only 45 days to respond to requests for medical records, although they can seek an extension if they submit the request within that time period, Apolskis says.

RACs are not designed to pursue fraud and abuse, and CMS provides them with access to a specialized data warehouse to prevent them from reviewing the same claims as other Medicare contractors, Apolskis adds.

Know what information to expect from RACs

RACs aren't required to advise providers of the results of automated reviews unless they discover an overpayment. They're supposed to advise providers of the results of complex reviews within 60 days of a site review or receipt of medical records, but they can request a waiver of that requirement from CMS.

When they discover a potential underpayment, RACs notify the appropriate Medicare contractor, which is responsible for validating the finding. The RAC is then expected to notify the provider in writing, citing the claim(s) and beneficiary detail.

However, the Medicare contractor, not the RAC, makes claim adjustments, Apolskis says. Moreover, providers don't have any official appeals rights in relation to underpayment determinations, only the RAC rebuttal process, which allows them to discuss an underpayment determination with a RAC.

Fortunately, RACs may not recoup or forward an overpayment claim to a Medicare contractor if the amount is less than $10. They're also prohibited from aggregating claims of less than $10 to pursue overpayment recoveries, so they can't nickel and dime a provider.

To recover overpayments—with interest, of course—the RAC program primarily uses recoupment: recovery of an outstanding Medicare debt by reducing present or future payments. RACs also must offer providers

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RACs

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the opportunity to repay an overpayment through an installment plan, and a small percentage of overpayments are resolved through a compromise settlement. Claims identified as overpayments are subject to the Medicare appeals process, but the RAC program includes some unique wrinkles, such as the rebuttal process, that make appeals less than palatable for many providers.

Put your compliance plan in motion

Hospitals and physician practices should use the following strategies to prepare for RACs:

- Examine CMS documentation on the RAC demonstration project and identify possible coding and billing practices that might invite scrutiny of your claims. The 2007 RAC status document and frequently asked questions about RACs are posted at *www.cms.hhs.gov/RAC.*
- Educate your organization's senior leadership, compliance committee, and possible targeted service lines about the RAC program. The focus of the RAC program is to reverse improper payments based on coding and billing errors. The best way to eliminate such errors is to follow the OIG model compliance plan and track the entire life cycle of your billing and collections system, Harlow says. A good compliance plan contains written policies and procedures to

RAC program a legacy of Medicare reform legislation

The recovery audit contractor (RAC) program, authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, has been contentious from the start. The three-year RAC demonstration program began in 2005 in California, Florida, and New York—states with the largest number of Medicare claims. Congress made the program permanent with the enactment of the Tax Relief and Health Care Act of 2006, and in 2007, CMS expanded the demonstration program into Massachusetts, South Carolina, and Arizona.

RACs identified more than $300 million in improper payments during each of the three years of the demonstration program, resulting in total recoveries of nearly $440 million from providers—mostly hospitals. But RACs identified less than $10 million in underpayments to providers.

"The demonstration project contractors focused on hospital overpayments, since each hospital case represents a larger dollar amount—and, thus, a larger contingency fee for the contractor," says **David C. Harlow, Esq.,** principal at The Harlow Group, LLC, in Newton, MA. "Physician practices will feel the impact more acutely in the future."

According to the fiscal year 2007 RAC status report released by CMS on February 28, most of the improper payments were attributed to medical necessity criteria for the setting where a service was rendered or to improper coding. Others were related to outdated fee schedules or insufficient documentation to support the claim.

When they discover an improper Medicare payment, RACs can demand that providers reimburse Medicare and refund incorrect copays to patients. The status report did not provide the average overpayment in the demonstration project but cited real-life examples of $1,221 for medical necessity and $1,504 for incorrect coding.

The use of RACs has improved the accuracy of Medicare payments to providers, according to CMS, which notes that incorrect claims submitted by healthcare providers as part of the Comprehensive Error Rate Testing program declined from 14.2% in 1996 to 3.9% in 2007. Nevertheless, there has been concern as to whether paying RACs on a contingency basis may distort contractor judgment.

"The government seems sanguine about paying contingency fees to RACs, noting that this is standard operating procedure in the private sector," Harlow says.

On November 7, 2007, Rep. Lois Capps (D-CA) introduced the Medicare Recovery Audit Contractor Program Moratorium Act of 2007 (H.R. 4105), which would suspend all activities under the RAC program for one year following enactment. Although Capps' bill has 33 cosponsors and the support of many state hospital associations, it has languished in committee.

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ensure that all services are coded properly and billed to the right payer and that staff members stay abreast of changes in codes. "Many well-written compliance plans just sit on the shelf, and that doesn't do your practice any good," Harlow says.

- If you're only implementing a compliance plan, select a manageable number of measures and grow the program organically over time. "It's important to bite off only as much as you can chew," Harlow says.
- Proactively self-audit charts and charges to identify codes or services that may need a corrective action plan. For example, if certain overpayments have been identified in your practice in the past, pull recent claims with a similar coding profile to ensure that you've fixed any systematic deficiencies. Self-audits may be conducted internally or through the use of a compliance consultant, Harlow says.
- Organize a task force that includes representatives from compliance, your attorney or outside counsel, and your medical director, Apolskis says. Develop a plan to respond to RAC medical record requests, reviews, and determinations. Identify a point person to receive and respond to communications from RACs—ideally, the person who is most knowledgeable about Medicare rules and claims—and develop a process to gather requested medical records and submit them on time. Train your staff to refer all communications with RACs to the designated respondent.
- Know how to navigate the Medicare appeals process and develop possible arguments and defenses to RAC determinations. Consider auditing the same claims selected by a RAC internally to verify the findings and ensure that all underpayments were found and reported as well. Review your current process for deciding whether and when to appeal overpayment notices from Medicare, and conduct a cost-benefit analysis to examine a potentially larger scope of overpayment notices and short appeal deadlines. "Build a mechanism to determine who will decide whether to appeal, and on what basis," Apolskis says.

Providers chose to appeal only 11.3% of 2007 RAC determinations, and only 5% of these were overturned on appeal. However, more than 40% of the appealed claims were decided in the provider's favor, suggesting that providers won a high volume of low-dollar appeal issues, Apolskis says. Establishing a materiality threshold can help your practice determine when the cost of internal and external resources outweighs potential recoveries from appealing a RAC denial, he adds. ■

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Use E/M coding audits to train your physicians

Learn how to improve coding in your practice in Part II of this two-part series

As discussed in the April **MCCRA,** a coding audit is an excellent tool for physician practices to determine what, if any, problems exist in their claims submissions, particularly for E/M codes. Part II of this coding spotlight illustrates how to use the findings of your audits to help your physicians improve their coding practices.

E/M codes affect not just outpatient or office consultations but home, skilled and unskilled nursing facilities, and ED visits, says **Jennifer Swindle, RHIT, CCS-P, CPC-EM-FP, CCP,** senior coding consultant at PivotHealth in Lafayette, IN. "Many practices audit their office visits. It's harder to get to the hospital records, but those visits also need to meet the documentation guidelines."

Coding the level of service should always be driven by the medical necessity of the visit, she adds. If physicians evaluate patients carefully and focus their coding perspective on the patient's illness, condition, or chief complaint, it's much easier to teach them to code appropriately "than trying to teach them how to count bullet points," Swindle says.

Share management tips and more with peers

"Practice Chat" is a talk group open to physicians, managers, practice administrators, and staff members who want to network, share best practices, and seek opinions, input, and advice.

Need help with scheduling dilemmas, handling difficult patients, or implementing medical records? By participating in "Practice Chat," you can share your ideas with peers across the country on these and other important topics and get their feedback and suggestions in return.

Members can post a message or question to the list 24 hours per day. "Practice Chat" also has a digest feature. Subscribers who want to receive all postings for the day in one message can do so by requesting the digest version rather than the regular version. Sign up today by e-mailing *owner-practice_chat@hcpro.com.*

"Educate physicians to document based on the medical necessity of the patient and the work that's required, instead of counting elements," says **Jeannie Cagle, RN, BSN, CPC,** senior consultant at The Coker Group in Alpharetta, GA.

In short, the amount of decision-making prompted by medical necessity—the complexity of the medical problems, the number of medications involved, and the differential diagnosing required—should drive the level of code selected. All of the supporting documentation, including diagnoses the physician ruled out or findings that were negative, should be recorded to support that code.

"Many physicians cheat themselves," Swindle says. "They document everything that's clinically relevant, but once they rule something out, they assume it doesn't need to go on the piece of paper. Think about that from a patient care perspective. If you've already ruled something out, but you're on vacation for a week when the patient comes back, other physicians need to know your findings to ensure continuity of care. It's not all about billing."

Code consults correctly

The key criteria in documenting new versus established patients is the time lapse since the patient's last visit. A patient who has not had a face-to-face encounter with the physician—or, in a group practice, a partner of the physician in the same specialty—within three years should be coded as a new patient, sources say.

In a multispecialty group using a single tax ID number, when a patient's been seen by one family medicine doctor, an encounter with any family medicine doctor in that group should be coded as an established patient. However, the patient might still be considered new to a specialist in the group.

Consultations are debated more than any other type of code. They're often misunderstood when several specialties are involved in a patient's care. In fact, the OIG

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estimates that 60% of consultations are miscoded, and these visits are ripe for Medicare audits.

When a patient is referred for care, the encounter isn't always a consultation, Swindle says. It is a consultation if a patient is referred so that another physician can render medical advice back to the requesting physician—even if the physician who was consulted determines that he or she should treat the patient. It's essential for the office staff to capture complete and accurate documentation, including the intent of the consultation. However, if a patient actually is referred for treatment because the scope of care exceeds the medical expertise of the requesting physician, the encounter should be coded as a new or established patient.

To select the appropriate code for the visit, physicians should consider the following:

- Was there a request from an appropriate source for evaluation and opinion?
- If so, is that request documented in the medical record, both from the physician requesting and the physician performing the consult?
- Was the service rendered?
- Was a report of the findings or opinion provided to the requesting physician or, in a group practice with a shared medical record, a note made in the chart?

"Without all of these pieces, a consultation code is not appropriate," Swindle says.

Know differences in E/M coding criteria

The three components that drive a physician's E/M coding in any setting are the patient's history and exam and the physician's medical decision-making. The e-tool below is a terrific guide to choose the appropriate level of service for new patients and consults in the office or

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E-TOOL Determining level of service for new patients/consultations in the office/outpatient setting

	99201/99241	99202/99242	99203/99243	99204/99244	99205/99245
All three key criteria MUST be met, with MEDICAL NECESSITY being the critical determining factor.					
Medical decision-making (2/3)	**Straightforward**	**Straightforward**	**Low**	**Moderate**	**High**
# diagnosis/treatment options	Minimum	Minimum	Limited	Multiple	Extensive
Amount of data ordered/reviewed	Minimum	Minimum	Limited	Moderate	Extensive
Table of risk (complexity)	Minimum	Minimum	Low	Moderate	High
History (3/3)	**Problem focused**	**Expanded problem focused**	**Detailed**	**Comprehensive**	**Comprehensive**
History of present illness	1–3 elements	1–3 elements	4+ or status of 3 chronic	4+ or status of 3 chronic	4+ or status of 3 chronic
Review of systems	None	Pertinent (1 system)	2–9 systems	10+ systems	10+ systems
Past, social, and family history	None	None	1–2 elements	all 3 elements	all 3 elements
Overall examination	**Problem focused**	**Expanded problem focused**	**Detailed**	**Comprehensive**	**Comprehensive**
Examination	1–5 bullets	6–11 bullets	12–17 bullets	18+ (2 ea in 9 systems)	18+ (2 ea in 9 systems)
Consults differ from visits in that there is a REQUEST for evaluation or opinion. The request must be clearly supported. If more than 50% of the visit is spent in counseling or coordination of care, billing on time is appropriate.					

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E/M coding audits

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outpatient setting. The table breaks down these visits by history, exam, medical decision-making, and code. The requirements for documentation are identical between new patient and consultation, although they're not a direct link to an established patient.

"If you look at the 99204 and the 99244, which is a high level of new patient or consultation, you need a comprehensive history and a comprehensive exam," Swindle says. "The only difference between a level 4 and a level 5 is the amount of medical decision-making involved. So if a physician has a comprehensive history and moderate medical decision-making but only documents six exam elements, that's a 99202 or 99242. It makes a huge difference in coding."

Use different criteria for established patients

When coding E/M visits for established patients, physicians only need to meet two of the three criteria, one of which should be medical decision-making, Swindle says.

Often, when physicians become comfortable with their understanding of 99213 compared to 99214, they try to translate those elements to new patients, substituting a 99213 for a 99203 or a 99214 for a 99204.

"The criteria are not the same," she says. "You need to know the difference between the two types of codes."

For providers who don't use electronic medical records (EMR), the documentation that is most likely to fall short is the history of present illness (HPI), says **Rose B. Shattuck, CPC, CCP, CHBME, PCS,** president and CEO of Physician Billing Solutions, LLC, and Rose Shattuck and Associates, LLC, both in Raleigh, NC. Even when a nurse or medical assistant has recorded a significant amount of information on the patient intake form, physicians must conduct the HPI, she adds.

"The history is a weak component for most physicians, especially for established patients," Shattuck says. "The nurse can do the review of systems and the chief complaint, but the physician has to restate the chief complaint and adequately document the history of present illness."

Even with an EMR, physicians need to understand that they just can't push a button and fill in a blank.

"The documentation has to be specific to the patient's encounter," she says.

Talk to physicians in their language

When presenting this type information to physicians, it's important to use terms they understand. "Telling a physician, 'Your history was only good enough for a 99213,' clicks better than using coding jargon," Cagle says.

Coders also can make copies of physician notes and circle or highlight items that count toward documentation requirements to use as teaching tools. Knowing which elements count toward documentation can save physicians a tremendous amount of dictation time, Cagle says.

The individual in the practice who's in charge of coding should regularly sit down with each physician, review a handful of charts, and break down each component of the medical record and notes. This process helps physicians see what information is needed to support their coding of patient encounters.

Continuing education for physicians and staff members is essential to stay abreast of constant changes in codes.

"Physicians need at least annual training on coding issues," Shattuck says. "They have to make time to do this. Not only will they improve their coding skills, but when they document correctly, there's a good chance the practice's revenue will increase." ■

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