

RAC UPDATE

News on the Medicare Recovery Audit Contractor Program

January 11, 2010

In recent discussions with AHA, the Centers for Medicare & Medicaid Services (CMS) provided the following updates on the Medicare Recovery Audit Contractor (RAC) program. This Update also includes recent RAC-related news and resources.

RAC Program Roll-out

Some Joint Operating Agreements Still Pending. All states are now eligible for RAC audits *if* the state's designated RAC has entered into a joint operating agreement with the state's Medicare claims processing contractor. For hospitals, the primary claims processing contractors are Medicare administrative contractor (MAC), which are in the process of replacing fiscal intermediaries (FIs) and carriers. A joint operating agreement must be in place before a RAC conducts audits since the claims processing contractors administer two steps needed to adjudicate RAC denials: 1) the recoupment of Medicare claims denied by a RAC; and 2) the first stage of the Medicare appeals process. Since final MAC selection is still pending in some of the 15 MAC regions¹, RACs in those areas are on hold until MAC selection is final, unless they enter into an interim agreement with the legacy carrier and/or FI. If your RAC has not yet initiated hospital audits, you may inquire with your RAC about the status of this agreement. The four separate contractors that process durable medical equipment claims have completed their RAC agreements.

Automated Audits. As of September, all four of the national RACs have begun conducting automated audits. CMS reports that the RACs have submitted approximately 250 total audit requests; approximately 50 have been approved through CMS' new issues review process. Automatic audits are conducted through software analysis of large batches of claims. In December and January, the RACs are expanding the types of claims being audited, as discussed below. Before proceeding with any audit, a RAC must receive CMS' approval and post the approved audit on its Web site. The links below provide details on each RAC's active audits.

¹ For a CMS listing of state assignments to the MAC jurisdictions, go to <http://www.cms.hhs.gov/MedicareContractingReform/Downloads/MACJurisdictionFactSheet.pdf>.

RAC	Web site	No. of Active Audits
RAC A -- DCS	http://www.dcsrac.com/portal.html	10
RAC B -- CGI	http://racb.cgi.com/	7
RAC C -- Connolly	http://www.connollyhealthcare.com/RAC	78
RAC D -- HDI	https://racinfo.healthdatainsights.com/	18

Complex Audits. The RACs are targeting the following roll-out dates for the three types of complex audits, which involve review of a medical record:

1. **Coding Validations:** The first round of coding audits was approved by CMS in December, with audits initiated this month.
2. **Diagnosis-related Group (DRG) Validations:** In December, Connolly began requesting medical records to conduct DRG validations. HDI and DCS are expected to begin this process in January.
3. **Medical Necessity Reviews (MNR):** In January, CMS expects the RACs to begin collecting 10-claim samples of MNRs. The RACs will submit the outcomes of these sample audits, along with other data, when requesting CMS' approval of an MNR audit through the "new issue review process." It appears that the RACs will have latitude when structuring these samples: They may collect a *single* sample from either one state, multiple states, or an entire RAC jurisdiction. RACs will inform hospitals of the outcome of any sample audit within 60 days via a review results letter. Only those claims that are part of an approved MNR audit will be subject to recoupment. If approved, a RAC will post the MNR on its Web site prior to proceeding with the audit on a broader scale.

Medical Record Request Limits

As we reported in *AHA News Now* on December 3, CMS has implemented a revised policy on the number of medical records that may be requested by RACs. CMS anticipates this policy will apply to all three types of complex audits. Under the new guidelines, a RAC may only request up to 200 medical charts per "hospital campus," per 45-day period, with exceptions for larger hospitals. In a change from its original proposal based on national provider identifier numbers, the definition of "hospital campus" includes all health providers that fall under the same organizational tax identification number *and* share the same first three zip code digits. All Medicare providers that fall within this definition of hospital campus, including non-inpatient providers and units, will be subject to one RAC limit. CMS' policy is available in Appendix A and online at <http://www.cms.hhs.gov/RAC/Downloads/DRGvalidationADRLimitforFY2010.pdf>.

Under the revised policy, the campus-specific limit will be set at one percent of a campus's claims for the prior calendar year. The policy also includes two exceptions that will allow RACs to exceed the 200 record cap. The first exception applies a higher limit of up to 300 medical records per 45-days to larger hospitals with more than 100,000 Medicare claims

per year. The second exception allows RACs to request CMS approval to exceed the 200 record maximum on a case-by-case basis. Also, the policy allows RACs to cluster record requests (and audit impact) disproportionately across the categories of hospital claims (inpatient, skilled nursing, etc.).

The AHA has several concerns and will urge CMS to clarify these issues and make changes to ensure fair application of the limits. We have encouraged CMS to urge the RACs to apply medical record requests proportionately across each hospital campus's claims mix. We also have requested details on the number and types of "high-volume" hospitals that CMS expects will be subject to the 300 record cap. In addition, we have requested that CMS articulate the maximum number of records per campus that the agency will approve in response to a hospital-specific request from a RAC.

Remittance Advice Update

As we reported in the last *RAC Update*, CMS' billing systems have not been able to properly use the N432 code designated for RAC claims and, as a result, the code is not appearing on remittance advices. CMS indicates that the necessary system corrections will be implemented through a two-stage process in April and July 2010. In the mean time, CMS and the RACs are developing an interim solution to allow the RAC remark code to function properly. In addition, CMS is working on a Medicare-wide edit to provide claim-level detail on the remittance advice both when a denial is reported and when the actual recoupment occurs; this should be completed by summer 2010.



***RAC*Trac Update**

Data Collection Begins This Month. *RAC*Trac, an AHA-sponsored Web-based survey to track the impact of RAC activity on hospitals, will start quarterly data collection in early January. AHA created *RAC*Trac to track and summarize the impact of RAC activity on hospitals nationwide. *RAC*Trac is designed to provide timely, reliable data that can be used to

advocate for changes to the RAC program going forward. The initial *RAC*Trac launch will take place in January 2010 and will focus on states that have had significant RAC activity by the end of the fourth quarter of 2009. As RAC activity ramps up, AHA will roll out *RAC*Trac nationwide. AHA encourages all hospitals with RAC audit activity to participate in *RAC*Trac. Please contact Elizabeth Baskett at ebaskett@aha.org or 202-626-2294 to sign up for *RAC*Trac today.

Free Claim-level Tracking Tool Available. The AHA has developed a free claim-level Excel tool to assist in tracking RAC audits. This tool is available to all hospitals. AHA also continues to work with vendors of RAC audit tracking tools to ensure that their products are "RACTrac" compatible, i.e., can quickly and easily summarize data for upload or entry into RACTrac. More information on these initiatives can be found at www.aha.org/rac under "RACTrac."

Pending RAC Reports

Several reports on the RAC program are pending:

- CMS' update on RAC demonstration appeals is expected this month.

- CMS' annual RAC report for FY 2009 is expected in the near future.
- A U.S. Government Accountability Office report to Congress on the RAC program is expected in January 2010.
- A report by the U.S. Department of Health and Human Services Office of the Inspector General, "Recovery Audit Contractors' Referrals of Potential Fraud and Abuse," is expected by September 2010.

Further Questions

For more information on the RAC program, visit www.aha.org/rac. If you have further questions, please e-mail Rochelle Archuleta at rarchuleta@aha.org or the AHA RAC information line at racinfo@aha.org. From mid-January through mid-May, please refer your RAC policy questions to Elizabeth Basket at ebaskett@aha.org.

CMS' Policy
Additional Documentation Requests (ADRs)
for RACs Requesting Medical Records for Audit

Additional Documentation Limits for FY 2010 for DRG Validation as of December 1, 2009

In response to feedback from the RACs, providers/suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program in FY 2010. These limits will be set by each RAC (CMS) on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit (defined below) may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior calendar year Medicare claims volume.

1. Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located. Using TINs will reduce the total number of limits that would have been imposed per organization under the previous draft policy, which was based on National Provider Identifiers, while factoring in ZIP codes will promote equitability for regional or national organizations. For example:
 - Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.
 - Provider B has TIN 123456780 and is physically located in 12345 as well as 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

Please note that the definition of a campus for RAC documentation request limits differs significantly from the definition in 42 CFR 413.65(a)(2) used to determine eligibility for provider-based billing.

2. Limits will be set at 1% of all claims submitted for the previous calendar year (2008), divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services. Note: FY 2010 limits are based on submitted claims, irrespective of paid/denied status and/or individual lines, although interim/final bills and RAPs/final claims shall be considered as a unit. For example:
 - Provider C billed 156,253 claims last year. The provider's additional documentation limit would be $(156253 * .01) / 8 = 195.31$, or 195 additional documentation requests per 45 days.
 - Provider D billed 50,000 inpatient claims, 75,000 outpatient claims, 20,000 SNF covered stays, 20,000 home health episodes of care, 250,000 physician claims, 10,000 inpatient rehab claims and 1,000 hospice claims. The total number of claims for this provider would equal 426,000. The provider's additional documentation limit would be $(426000 * .01) / 8 = 532.5$. The provider's additional documentation limit would be 532 additional documentation requests every 45 days, if there were no cap in place (see below).

While respecting a provider's overall limit, the RAC may exercise discretion in the exact composition of an additional documentation request. For example, the RAC may request inpatient records up to the full limit even though the provider's inpatient business may only be a small portion of their total claim volume.

3. Two caps will exist in FY 2010: Through March 2010, the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers. However, from April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per TIN, across all claims processing contractors) will have a cap of 300 additional documentation requests per campus unit, per 45 days.
4. In addition, in FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.

Questions concerning this update can be directed to RAC@cms.hhs.gov.