



Measuring, Preventing and Correcting Improper Payments

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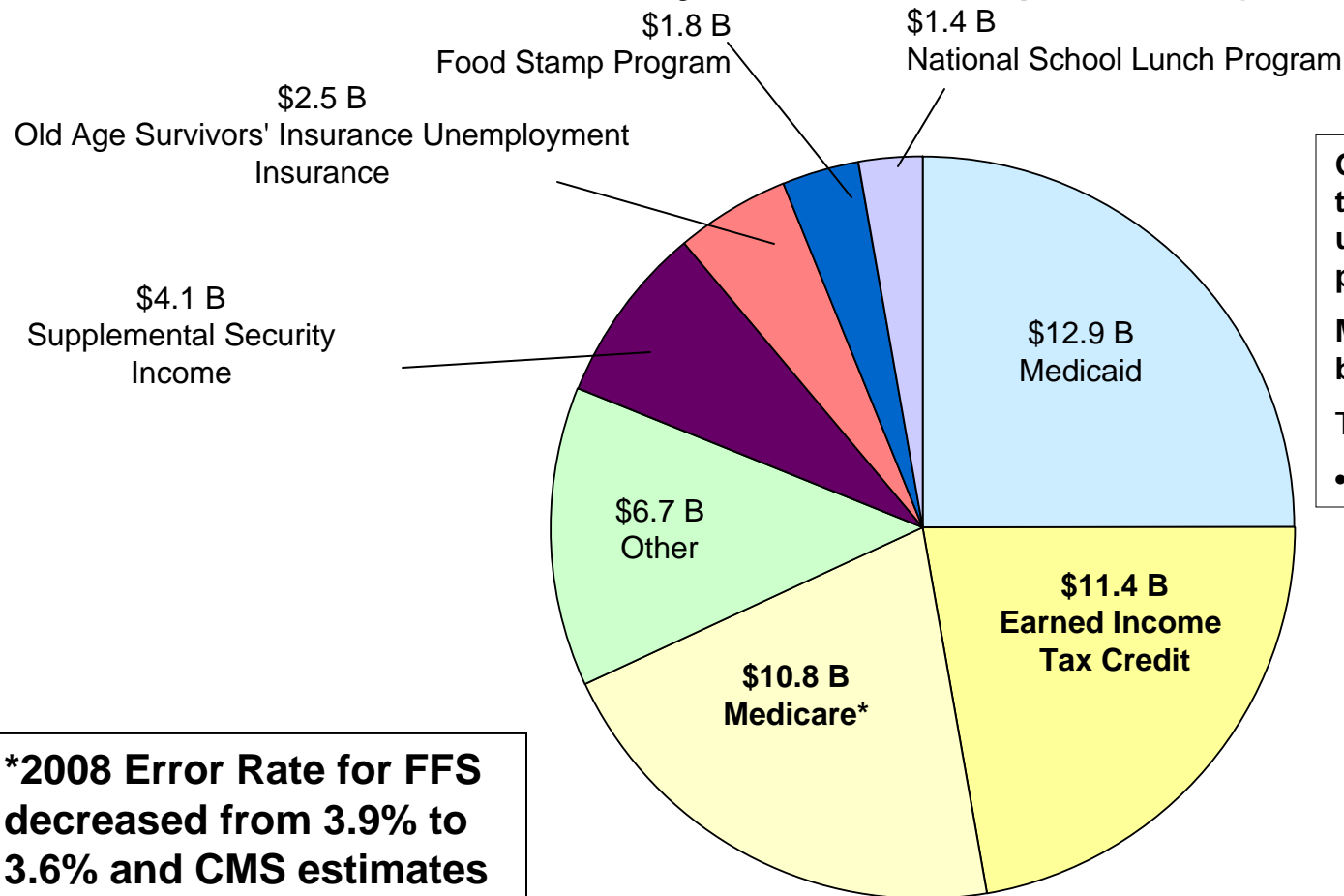
Disclosure: Nothing to Disclose



Agenda

1. Improper Payments in Medicare
2. Roles of Various Medicare Contractors
2. CERT contractor
3. Carriers/FIs and MACS
4. RACs

Top 8 Federal Programs with Improper Payments (2007)



Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.

Medicare receives over 1.2 billion claims per year.

This equates to:

- 4.5 million claims per work day

***2008 Error Rate for FFS decreased from 3.9% to 3.6% and CMS estimates to have saved over \$400 million in the last FY**

Roles of Various Medicare Improper Payment Review Entities

	Types of Claims	How selected	Volume of Claims	Purpose of Review
Overseen by CMS Office of Clinical Standards and Quality	Inpatient Hospitals	All claims where hospital submits an adjusted claim for a higher-weighted DRG	Very small	To prevent improper payments through DRG up-coding
		Expedited Coverage Reviews requested by beneficiaries		To resolve discharge disputes between beneficiary and hospital
Overseen by CMS's Provider Compliance Group	CERT	Randomly	Small	To measure improper payments
	Carrier/FI/MAC	Targeted	Depends on number of claims with improper payments for this provider	To prevent future improper payments
	RAC	Targeted	Depends on number of claims with improper payments for this provider/item/service	To detect and correct past improper payments
Overseen by CMS' Program Integrity Group	PSC/ZPIC	Targeted	Depends on number of potentially fraudulent claims submitted by provider	To identify potential fraud
	OIG	Targeted	Depends on number of fraudulent claims submitted by provider	To identify fraud



Recent Changes to the CERT Program

- Review of randomly selected inpatient hospital claims to measure improper payments formerly performed by QIOs



Recent Changes for the Carriers, FIs, MACs

- Review of targeted inpatient hospital claims to prevent improper payments



What is a RAC?

RAC Program Mission

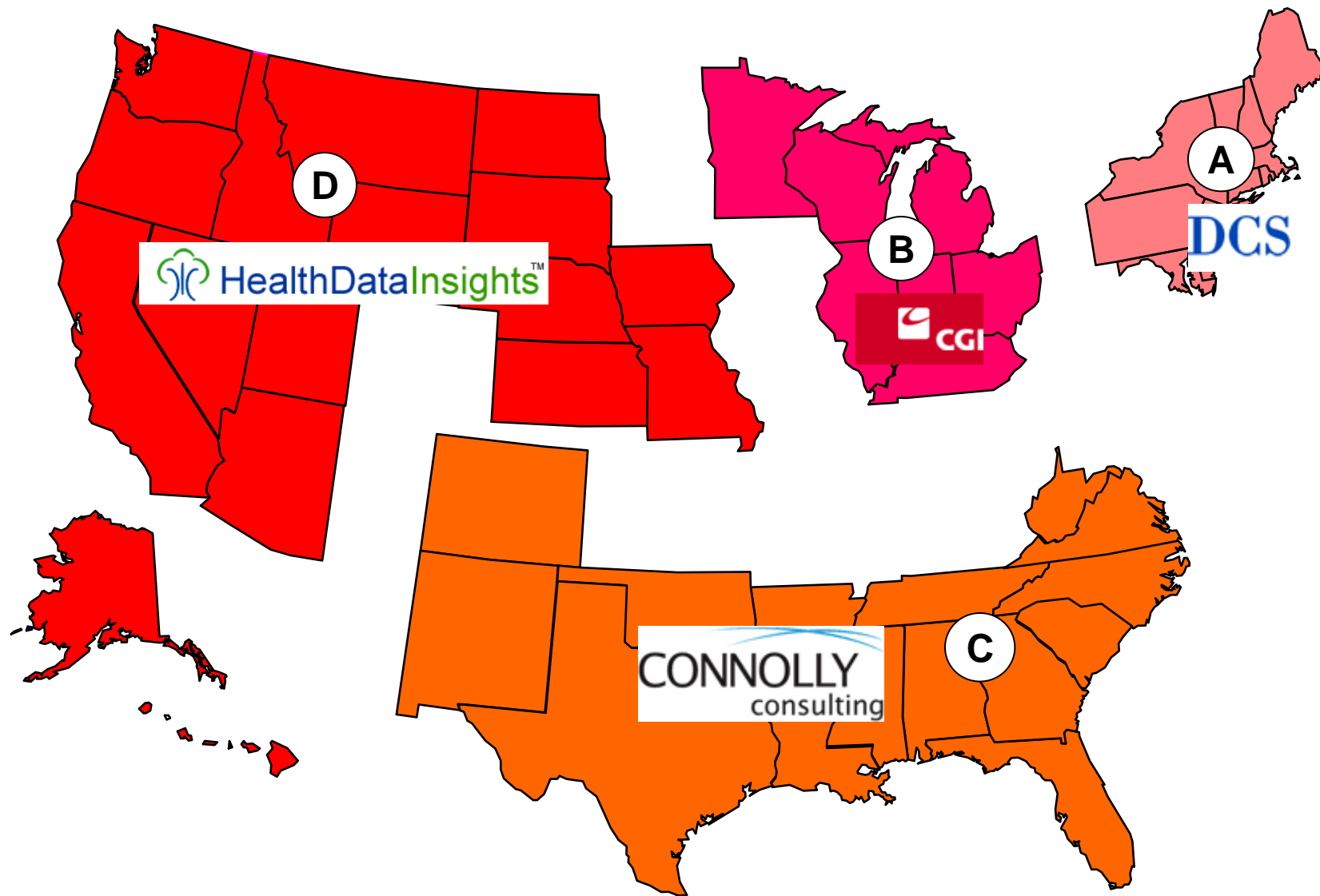
- The RACs detect and correct past improper payments so that CMS and the Carriers, FIs, MACs can implement actions that will prevent future improper payments
 - **Providers** can avoid submitting claims that do not comply with Medicare rules
 - **CMS** can lower its error rate
 - **Taxpayers** and future Medicare beneficiaries are protected

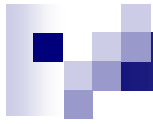


Will the RACs affect me?:

- Yes, if you bill Fee-For-Service programs, your claims are subject to review by the RACs
- If so, When?

RAC Jurisdictions





Why do we have RACs?



RAC Legislation:

- Medicare Modernization Act, Section 306:
 - Required the 3-year RAC demonstration
- Tax Relief and Healthcare Act of 2006, Section 302:
 - Requires a permanent and nationwide RAC program by no later than January 1, 2010
- Both of these statutes gave CMS the authority to pay the RACs on a contingency fee basis



What does a RAC do?



RAC Review Process

- RACs review claims on a post payment basis
- RACs use the same Medicare policies as Carriers, FIs and MACs
 - NCDs, LCDs, CMS manuals
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- RACs will NOT be able to review claims paid prior to October 1, 2007
 - RACs will be able to look back three years from the date the claim was paid
- RACs are required to employ a staff consisting of nurses, therapists, certified coders & a physician CMD



The Collection Process

- Same as for Carrier/FI/MAC identified overpayments
 - Carrier/FI/MAC issue Remittance Advice
 - Remark Code N432: “Adjustment Based on Recovery Audit”
 - Carrier/FI/MAC recoups by offset unless provider has submitted a check or provider has submitted a valid appeal



What is different?

- Demand letter is issued by the RAC
- RAC will offer an opportunity for the provider to discuss the improper payment determination with the RAC (this is outside the normal appeal process)
- Issues reviewed by RAC will be approved by CMS in most cases prior to widespread review
- Approved issues will be posted to a RAC website before widespread review




What are the providers'
options?



If you **agree** with the RAC's determination:

1. Allow recoupment (OP + int) on Day 41 and do not appeal
2. Pay by check on or before Day 30 (interest is not assessed) and do not appeal
3. Request or apply for an extended repayment plan (OP+ int) and do not appeal



If you **disagree** with the RAC's determination:

1. Allow recoupment (OP + int) on Day 41 and file an appeal by Day 120
2. Pay by check on or before Day 30 (interest is not assessed) and file an appeal by Day 120
3. Stop the recoupment by filing an appeal prior to Day 31
4. Request or apply for an extended payment plan (OP + int) and appeal by Day 120



RAC Program's Three Keys to Success

1. Minimize Provider Burden
2. Ensure Accuracy
3. Maximize Transparency



Minimize Provider Burden

- Limit the RAC “look-back period” to three years
 - Maximum look back date is October 1, 2007
- RACs will accept imaged medical records on CD/DVD (CMS requirements coming soon)
- Limit the number of medical record requests
- Allow submission of imaged medical documentation



Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
 - 10% of average monthly Medicare claims (max of 200) per 45 days per NPI

- **Other Part A Billers (HH)**
 - 1% of average monthly Medicare services (max of 200) per 45 days per NPI

- **Physicians** (including podiatrists and chiropractors)
 - Sole Practitioner: **10** medical records per 45 days per NPI
 - Partnership of 2-5 individuals: **20** medical records per 45 days per NPI
 - Group of 6-15 individuals: **30** medical records per 45 days per NPI
 - Large Group of 16+ individuals: **50** medical records per 45 days per NPI

- **Other Part B Billers** (DME, Lab, Outpatient Hospital)
 - 1% of average monthly Medicare services (max 200) per 45 days per NPI



Submitting Imaged Medical Documents to RACs

- Providers and clearinghouses can submit medical records to the RACs via several methods:
 - Mailed Paper
 - Fax
 - Mailed CD/DVD containing imaged medical documentation

NOTE: RACs have the discretion to accept imaged documentation via other methods. Contact your RAC to determine if other documentation submission options are available in our area.



Ensure Accuracy

- Each RAC employs:
 - A physician CMD
 - Certified coders
 - Nurses and/or Therapists
- CMS' New Issue Review Board provides greater oversight
- RAC Validation Contractor provides annual accuracy scores for each RAC
- If a RAC loses at any level of appeal, the RAC must return the contingency fee



Maximize Transparency

- New issues are posted to the web
- Vulnerabilities are posted to the web
- RAC claim status website (2010)
- Detailed review results letter following all complex reviews




What can Providers do to get ready?



Know Where Previous Improper Payments Have Been Found

- Look to see what improper payments were found by the RACs:
 - ✓ Demonstration RAC findings: www.cms.hhs.gov/rac
 - ✓ Permanent RAC findings: will be listed on the RACs' websites
- Look to see what improper payments have been found in OIG and CERT reports
 - ✓ OIG reports: www.oig.hhs.gov/reports.html
 - ✓ CERT reports: www.cms.hhs.gov/cert



Know if you are submitting claims with improper payments?

- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Identify corrective actions to implement for compliance



Prepare to Respond to RAC Medical Record Requests

- Tell your RAC the precise address and contact person they should use when sending Medical Record Request Letters
 - ✓ Call RAC
 - ✓ No later than 1/1/2010: use RACs' websites

- When necessary, check on the status of your medical record (Did the RAC receive it?)
 - ✓ Call RAC
 - ✓ No later than 1/1/2010: use RACs' websites

Who will be in charge of responding to RAC Medical Record requests?

What address will we use?

Who will be in charge of tracking our RAC Medical Record requests?




Appeal When Necessary

- The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC denials
- Don't confuse the "RAC Discussion Period" with the Appeals process
If you disagree with the RAC determination...
 - ✓ Do not stop with sending a Discussion Letter
 - ✓ File an appeal before the 120th day after the Demand Letter

Who will be in charge of deciding whether to appeal a RAC denial?

How will we keep track of what we want to appeal, what we have appealed, what our overturn rate is, etc.?



Learn From Your Past Experiences

- Keep track of denied claims
- Look for patterns
- Determine what corrective actions you need to take to avoid improper payments

Who will be in charge of tracking our RAC denials, looking for patterns?

How will we avoid making similar improper payment claims in the future?



RAC@cms.hhs.gov

www.cms.hhs.gov/RAC