MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Remember: The Transition to ICD-10 is Coming October 1, 2013 - On October 1, 2013, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues. Ask your clearinghouse, billing service or software vendor what you need to do to be ready for ICD-10. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at *http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf* on the CMS website.

MLN Matters® Number: SE1024
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted

This is the first in a series of articles that will disseminate information on RAC high dollar improper payment vulnerabilities. The purpose of this article is to provide education regarding RAC demonstration-identified vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider Types Affected

This article is for all Inpatient Hospital and Skilled Nursing Facility providers that submit fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

Provider Action Needed

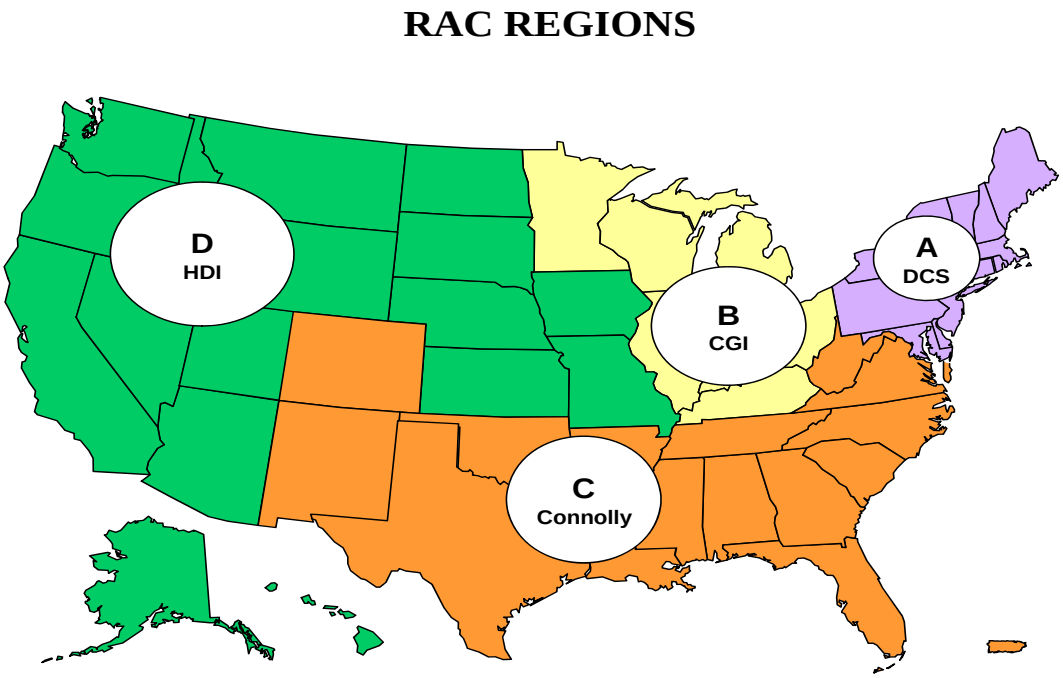
Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

Background

The *Medicare Modernization Act of 2003* (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the Recovery Audit Contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008. The success of the demonstration resulted in the passage of legislation in the *Tax Relief and Healthcare Act of 2006, Section 302,* which required CMS to establish a National RAC Program by January 1, 2010.

CMS uses four RACs to implement the National RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.

Figure 1:



The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation; and

- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

Medical Documentation Reminders

CMS reminds providers that medical documentation must be submitted within 45 days of the date of the Additional Documentation Request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

Actions to Assist Providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters;
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation;
- RACs must accept and review extensions requests if providers are unable to submit documentation timely;
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim;
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records;
- RACs must implement the RAC look back date of 3 years with a maximum look back date of October 1, 2007;
- RACs must limit the number of medical records requests every 45 days;
- RACs must indicate the status of a provider's additional documentation requests on their claim status websites;
- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and
- RACs must post all approved issues under review on their websites.

Preparing for RAC Audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact can be found on the individual RAC web pages listed at the end of this article. Providers can also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

CMS RAC Website Information

The following list identifies information unique to each of the four RACs, the States they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

RAC Region A- Diversified Collection Services (DCS), Inc. of Livermore, California:

- States in Region: Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- Subcontractors: PRGX (formerly PRG Schultz) and Health Technologies
- Email: Info@dcsrac.com
- Website: *http://www.dcsrac.com/portal.html*

RAC Region B- CGI Technologies and Solutions, Inc. of Fairfax, Virginia:

- States in Region: Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- Subcontractor: PRGX
- Email: racb@cgi.com
- Website: *http://racb.cgi.com/*

RAC Region C- Connolly, Inc. of Philadelphia, Pennsylvania:

- States in Region: Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North

Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).

- Subcontractor: Viant
- Email: racinfo@connollyhealthcare.com
- Website: *http://www.connollyhealthcare.com/RAC/*

RAC Region D- HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- States in Region: Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- Subcontractor: PRGX
- Email: racinfo@emailhdi.com
- Website: *https://racinfo.healthdatainsights.com/*

Additional Information

Providers are also encouraged to visit the CMS RAC website at *http://www.cms.gov/RAC* for updates on the National RAC Program. On that website, you can register to receive email updates and view current RAC activities nationwide.