STATE OF THE RAC UNION

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Vice President, Government Relations

CMS

The vast majority of Medicare providers are doing their jobs right and RACs are working within their authority.

Ensuring accuracy, efficiency and effectiveness are key to RAC success. CMS works to make the RAC program as efficient and effective as possible by minimizing provider impact and administrative cost.

CMS is sensitive to the concerns of the provider and continues to work with these communities to reduce the burden of the review process.

CONGRESS

RACs are an important program integrity tool. They are focusing on a legitimate discrepancy in Medicare payments. They are responding to the incentives.

Rep. Kevin Brady

Congress and Medicare should work to simplify the way audit contractors interact with providers.

Sen. Max Baucus

We need to achieve a balance of safeguarding Medicare finances while avoiding costly burdens on hospitals and health care providers that are affecting their ability to care for patients.

Sen. Jerry Moran

PROVIDERS

RACs are bounty hunters paid a contingency fee based on the money clawed back from denied claims.

RACs are second guessing physicians.

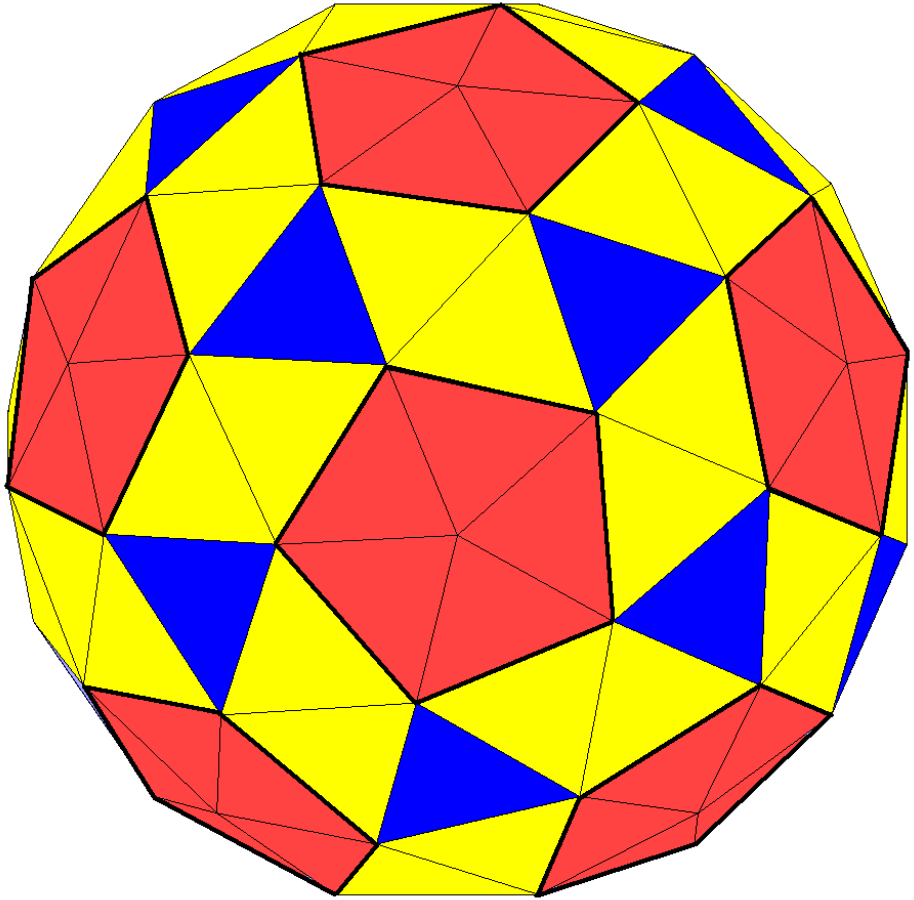
RACs are often inaccurate and inflict avoidable legal and administrative costs on hospitals.

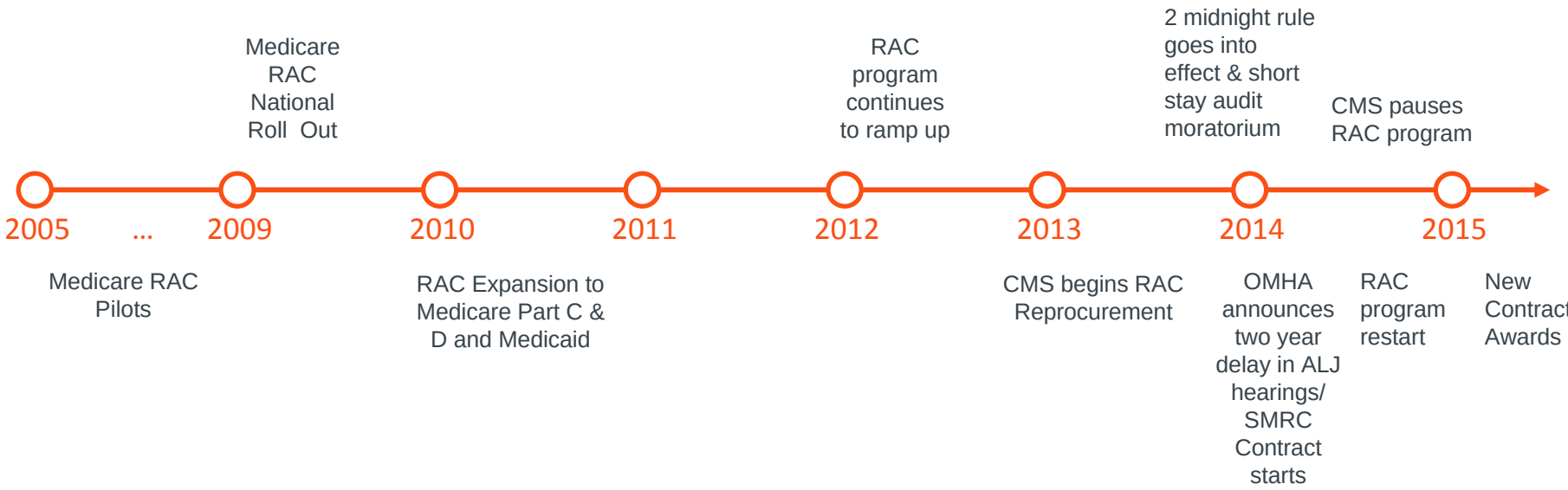
RACS

We are 100% incentivized to work accurately and precisely and only pursue claims which have been improperly paid.

Our work is strictly governed by CMS—more so than other CMS audit contractor.

We are paid a small portion of the proceeds that we recover and must return ALL of our fee if our determinations are found to be incorrect.

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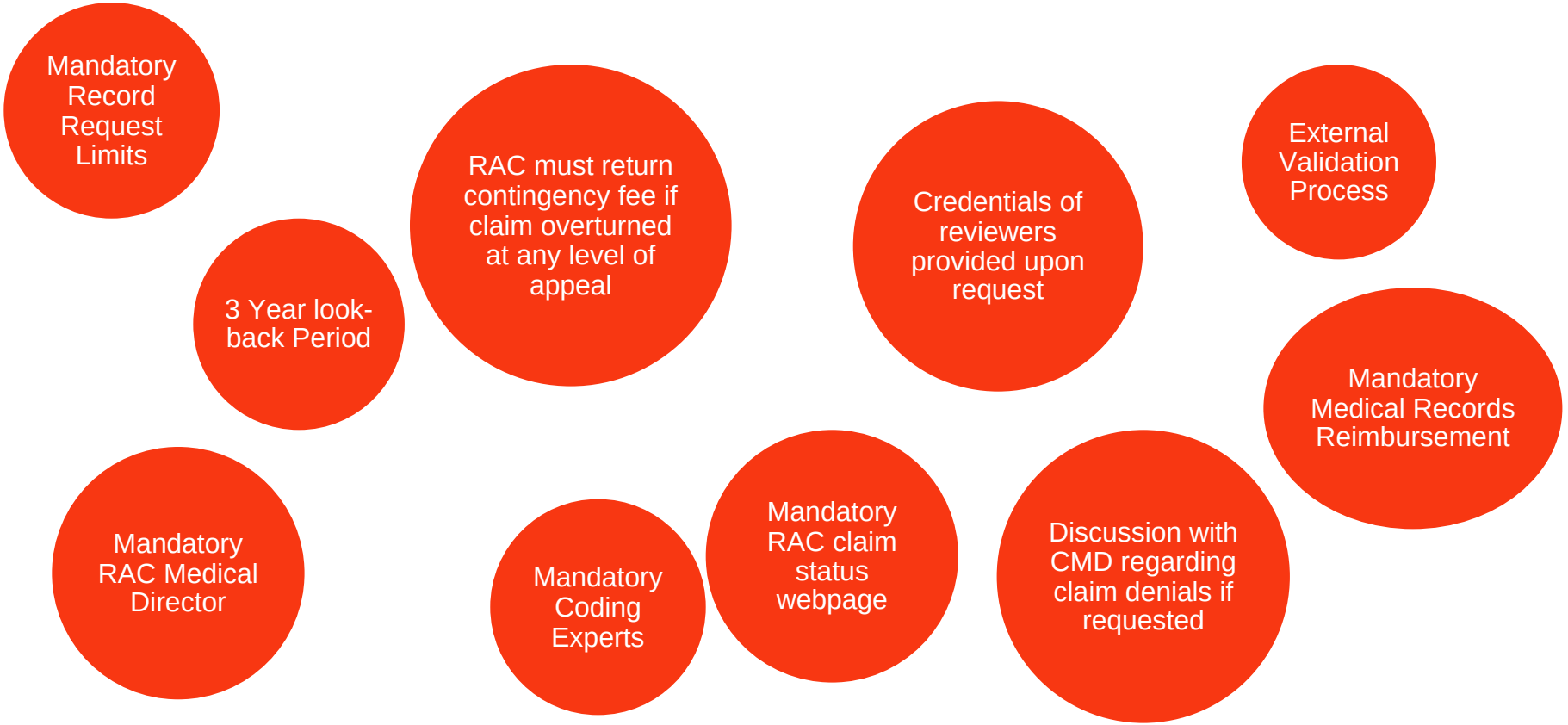
CMS pauses RAC program
RAC program restart
New Contract Awards

RAC REQUIREMENTS

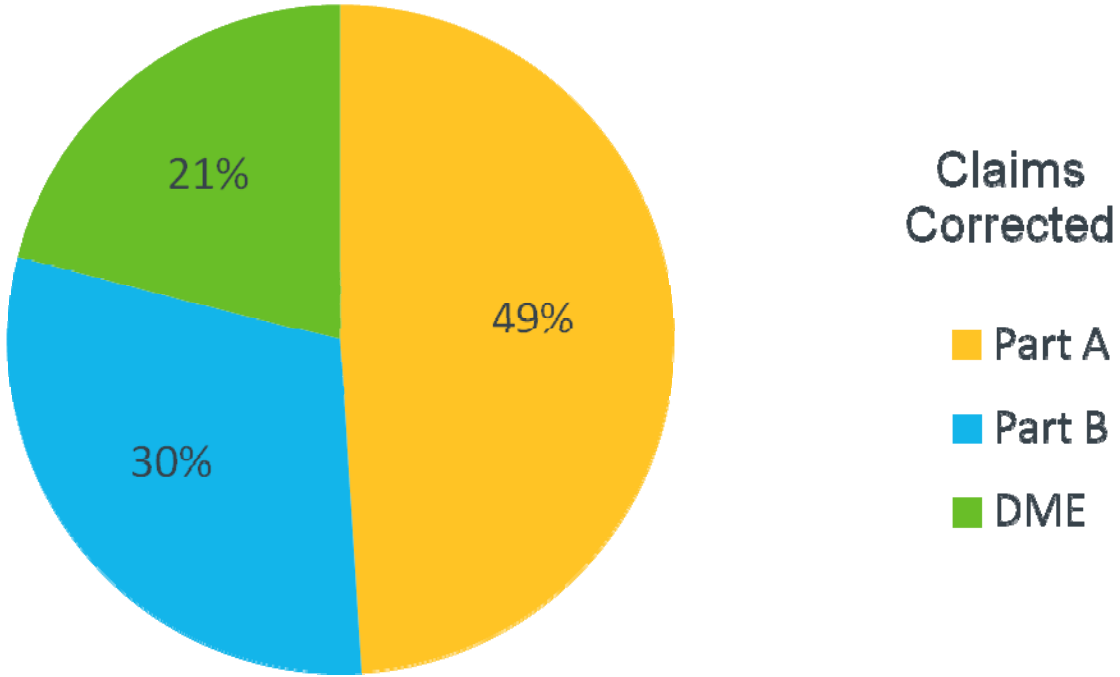


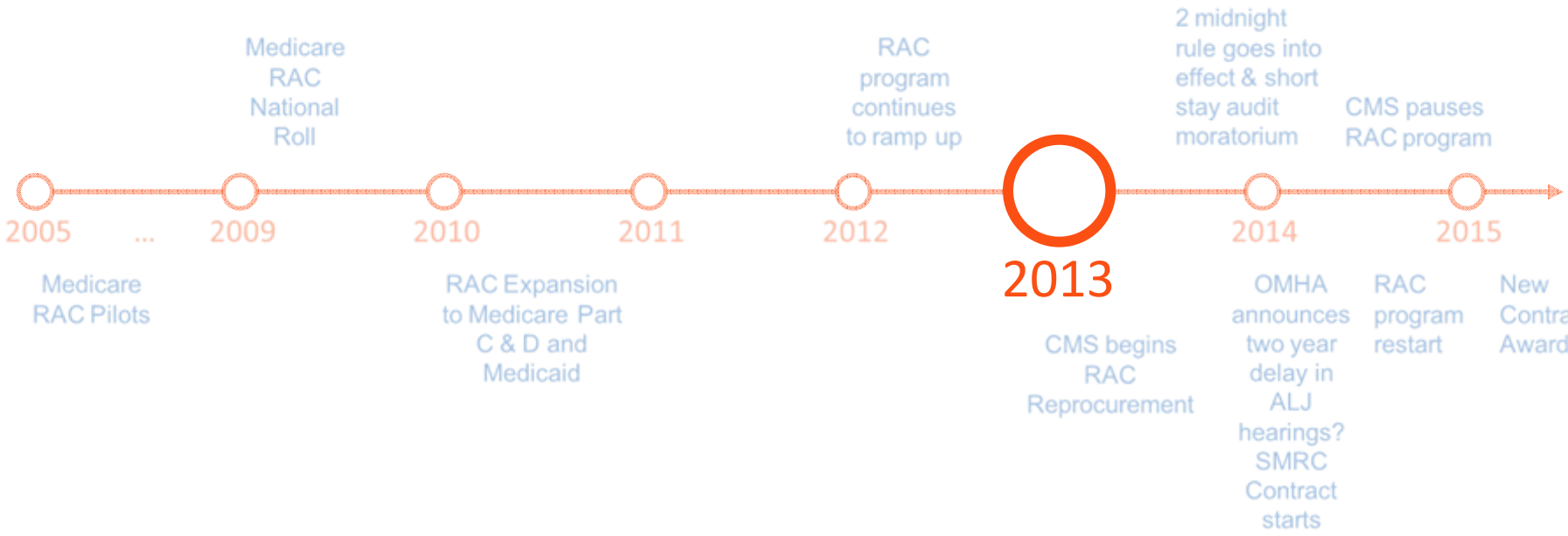
RACs COMPARED TO OTHER CONTRACTORS

	MACs	ZPIC	CERT	RACs
Selection of Claims for postpayment review				
CMS approval of criteria for selecting billing issues prior to widespread use	N	N	n/a	Y
Provider notice of issues targeted for review				
Provider notice (on website) of billing issues targeted for postpayment review	N	N	n/a	Y
Additional documentation requests (ADR) Provider reimbursement for copies of medical records	N	N	N	some
Limits on number of ADRs contractor can request from provider	N	N	N	Y
Reviews				
Authority to deny claim for minor omissions	Y	Y	Y	N
Provider communication				
Provider notification regardless of review outcome	N	N	N	Y
Reviewer's credentials available upon provider request	N	N	N	Y
Access to contractor's medical director to discuss claim denials upon request	N	N	N	Y
40 days to discuss any revision to initial determination informally prior to having to file an appeal	N	N	N	Y
Quality assurance				
External validation of randomly selected claims by independent contractor	N	N	N	Y

FY 2013 RAC REPORT TO CONGRESS

October 2012 – September 2013

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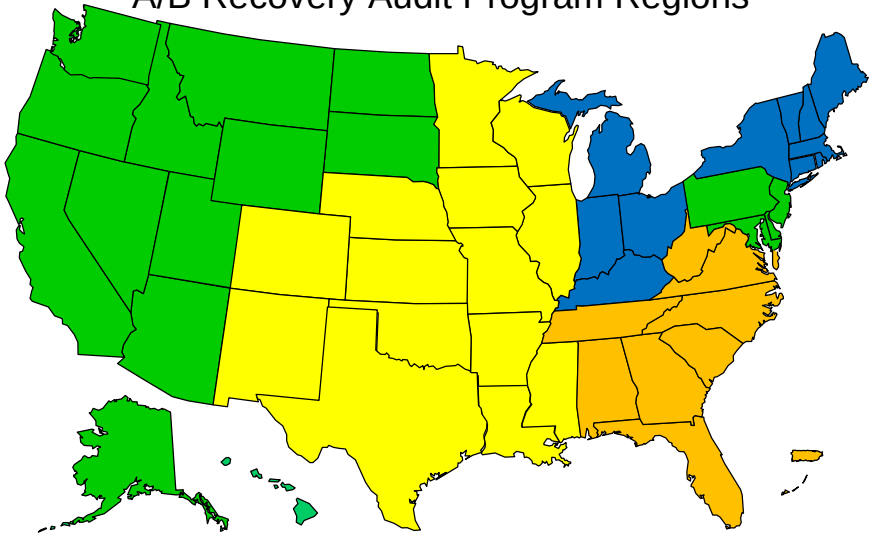
CONTRACT CHANGES

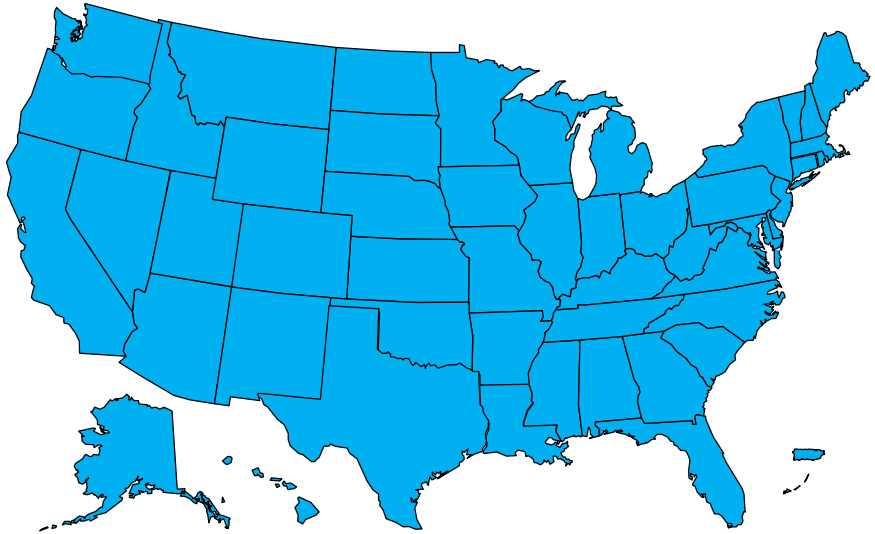
A/B Recovery Audit Program Regions



Region 1 Region 2 Region 3 Region 4

Effective Date: TBD

DME&HH/H Recovery Audit Program Region



Effective Date: TBD

CONTRACT CHANGES

Concern	Program Change
Upon notification of an appeal by a provider, the Recovery Auditor is required to stop the discussion period.	Recovery Auditors must wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
Providers do not receive confirmation that their discussion request has been received.	Recovery Auditors must confirm receipt of a discussion request within three days.
Recovery Auditors are paid their contingency fee after recoupment of improper payments, even if the provider chooses to appeal.	Recovery Auditors must wait until the second level of appeal is exhausted before they receive their contingency fee.
Additional documentation request (ADR) limits are based on the entire facility, without regard to the differences in department within the facility.	The CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient).
ADR limits are the same for all providers of similar size and are not adjusted based on a provider's compliance with Medicare rules.	CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.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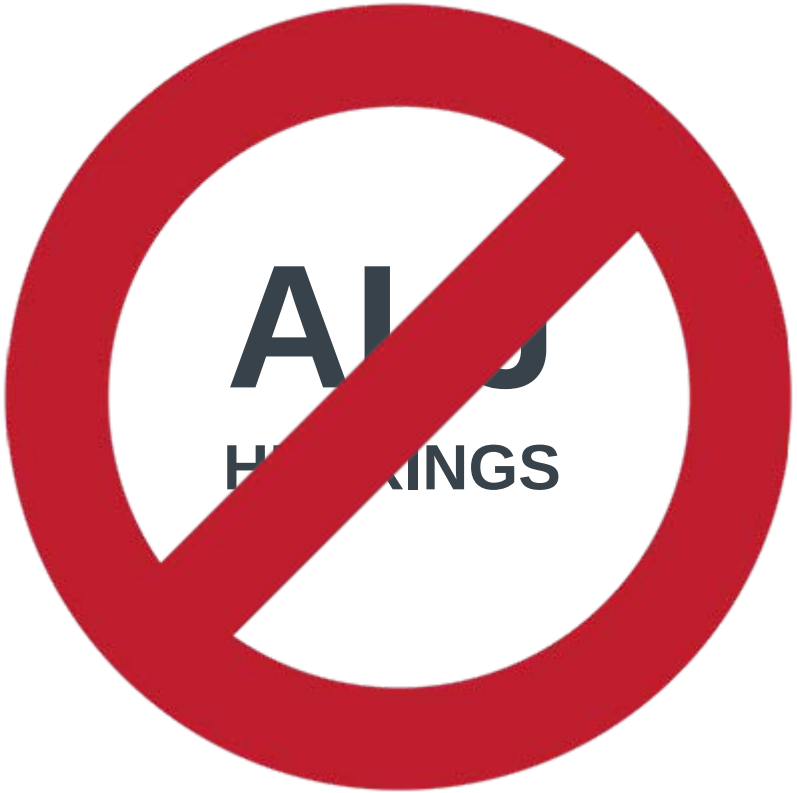
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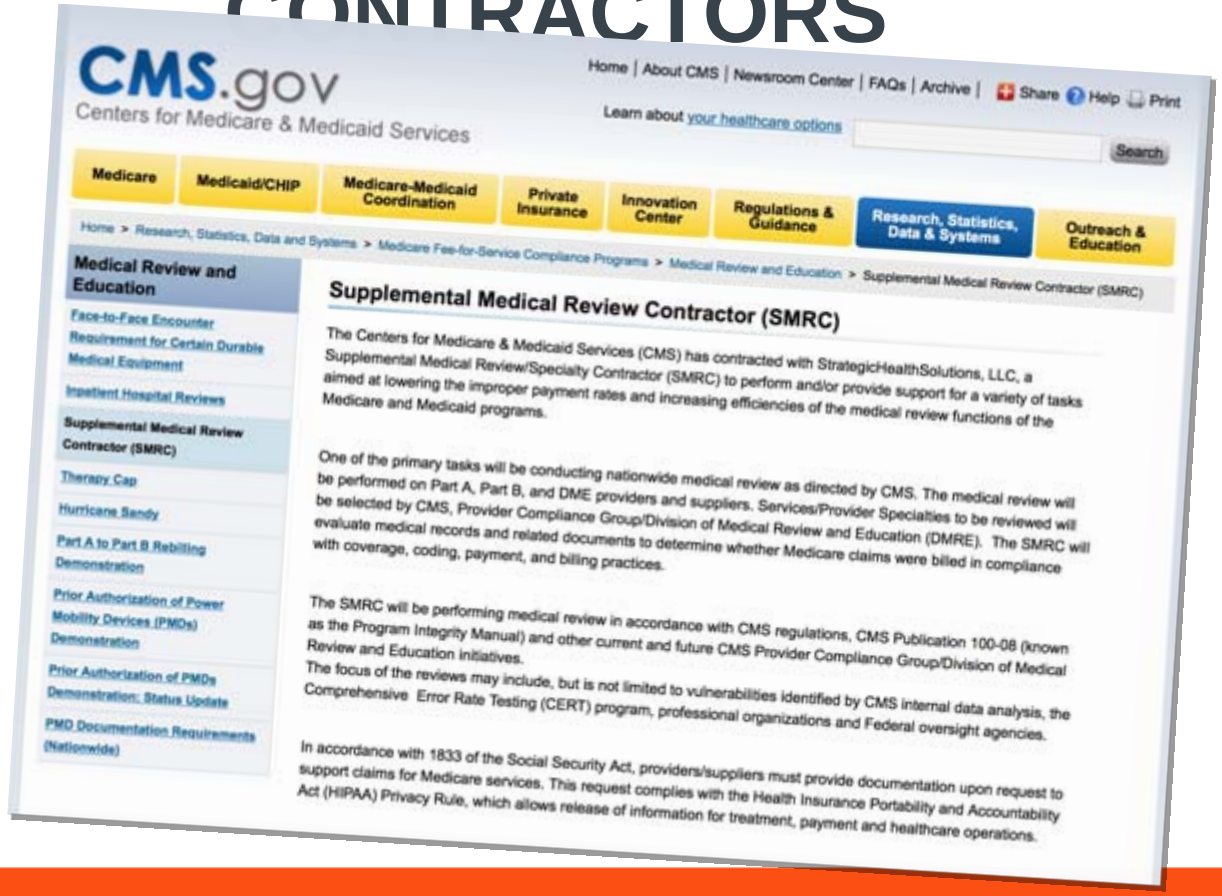
SUPPLEMENTAL MEDICAL REVIEW CONTRACTORS



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Home > Research, Statistics, Data and Systems > Medicare Fee-for-Service Compliance Programs > Medical Review and Education > Supplemental Medical Review Contractor (SMRC)

Medical Review and Education

- Face-to-Face Encounter Requirement for Certain Durable Medical Equipment
- Inpatient Hospital Reviews
- **Supplemental Medical Review Contractor (SMRC)**
- Therapy Cap
- Hurricane Sandy
- Part A to Part B Rebilling Demonstration
- Prior Authorization of Power Mobility Devices (PMDs) Demonstration
- Prior Authorization of PMDs Demonstration: Status Update
- PMD Documentation Requirements (Nationwide)

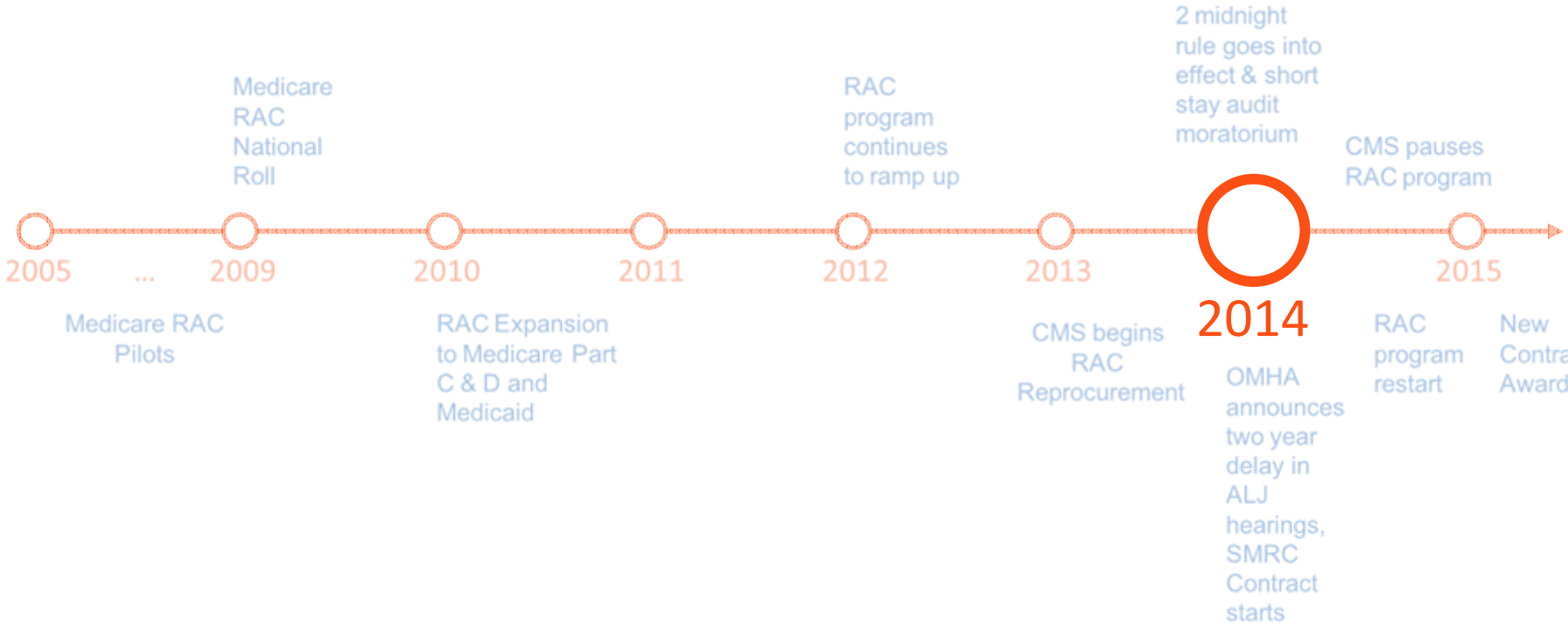
Supplemental Medical Review Contractor (SMRC)

The Centers for Medicare & Medicaid Services (CMS) has contracted with StrategicHealthSolutions, LLC, a Supplemental Medical Review/Specialty Contractor (SMRC) to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs.

One of the primary tasks will be conducting nationwide medical review as directed by CMS. The medical review will be performed on Part A, Part B, and DME providers and suppliers. Services/Provider Specialties to be reviewed will be selected by CMS, Provider Compliance Group/Division of Medical Review and Education (DMRE). The SMRC will evaluate medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices.

The SMRC will be performing medical review in accordance with CMS regulations, CMS Publication 100-08 (known as the Program Integrity Manual) and other current and future CMS Provider Compliance Group/Division of Medical Review and Education initiatives.
The focus of the reviews may include, but is not limited to vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Federal oversight agencies.

In accordance with 1833 of the Social Security Act, providers/suppliers must provide documentation upon request to support claims for Medicare services. This request complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information for treatment, payment and healthcare operations.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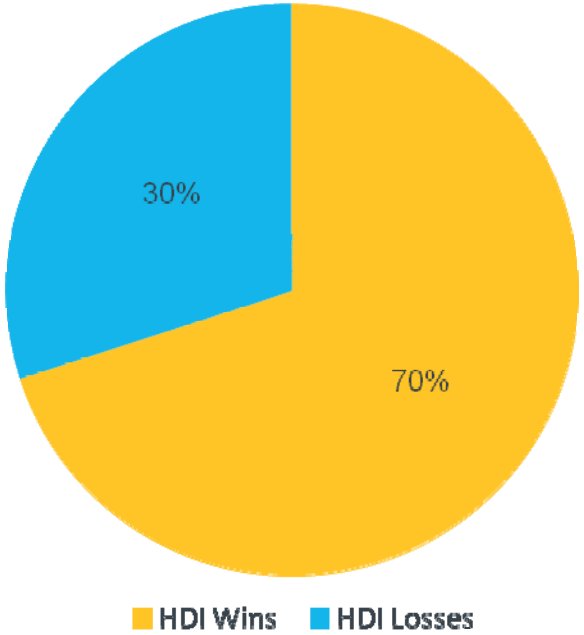
FY 2014 HDI APPEALS

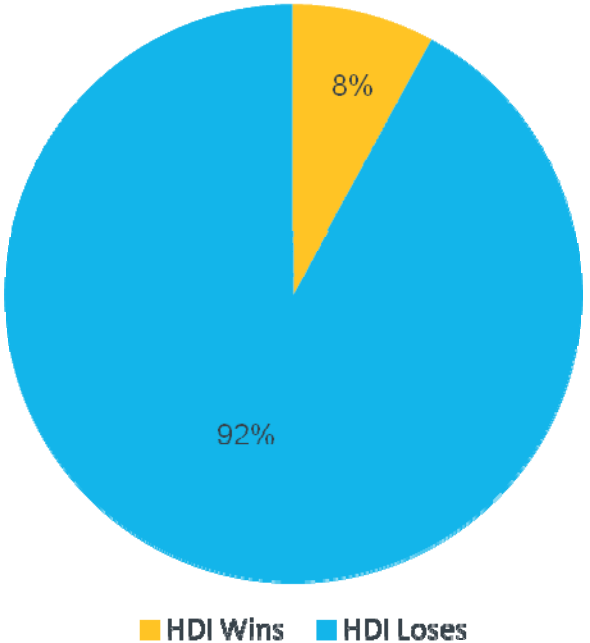
ALJ Decisions with HDI Attending Hearing*



*HDI receives only 11% of notices to attend hearings

On the Record Decisions

FY 2014



*HDI has no opportunity to participate for CMS

RECOMMENDATIONS

Collaboration among stakeholders

- Increase dialogue between RACs, policymakers and other stakeholders to improve the RACs, preserve the Medicare Trust Fund and protect tax dollars from improper payment

Appeals Reform

- Implement ALJ training on Medicare policy
- Increase ALJ judges
- Review use of “on the record” decisions by ALJs

Provider Education

- Increase front-end education of providers.
- Leverage Recovery Audit findings and expertise.

MEDICAID RACS

MEDICAID RACS VS. MEDICARE RACS

Medicare RACs	Medicaid RACs
Administered by CMS	Administered by States
One Reimbursement Policy	50+ Different Reimbursement Policies
Standard approach to providers	State and local provider concerns
CMS determines scope of audit	State decides what to include in audit
Prohibited from provider education	Provider education about flagged claims
Limited coordination	Must coordinate with other state audits

HMS' MEDICAID RAC

- Reduce provider abrasion, provide education, customer service and limit administrative costs.
- Possess in depth knowledge of state specific Medicaid policies, regulations, CPT coding standards, etc…
- Maintain an understanding of the state's operating environment – political, provider associations, agency goals.
- Experience in coordinating with other state audit entities.
- Have established processes for a) Receiving and Formatting Medicaid Data, b) proven provider relations and c) seamless recovery function.

OVERVIEW OF REVIEW PROCESS

Analysis And Targeting

- Program Analysis
- Data Mining/Scenario Design
- Review both Underpayments & Overpayments
- State Approval of Audit Issue

Record Request

- Provider Contact
- Record Request/Receipt
- Tracking/follow up

Review/Audit

- RN/Coder Review
- Physician Referral
- QA and Client Review/Approval

Notification and Recovery

- Notification Letter
- Reconsideration/Appeal
- Recovery Support

Education, Process Improvement

- Provider Association Meetings
- Program Recommendations
- Newsletter/Website

HMS METHODS OF COMMUNICATION

- Introductory Meetings
- Provider Webinars
- Articles in State or Association Newsletters
- Internet Outreach: http://www.medicaid-rac.com/providers/
- Provider Relations Team at Toll-free (855) 699-6290
- Post Review Debriefs
- Secure Provider Portal

HMS' PROVIDER PORTAL

- The Provider Portal is a secure website that allows providers manage their Medicaid RAC reviews.
- More than 20,000 providers currently use HMS's Provider Portal.
- Contact information can be updated by providers.
- Contains HMS contacts.

MEDICAID RAC CHALLENGES

- Conflicting state and federal policy and interests
- Timeliness and access to data
- Scope limitations
- Crossover of non-applicable Medicare RAC requirements

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