



Title: CMS's Medicare and Medicaid Audits (RAC and MIP Programs)

Part I: Recovery Audit Contractor (RAC) Program Introduction

CMS has recently implemented Medicare and Medicaid integrity systems. Although the details and components of the RAC (Medicare) and MIP (Medicaid) programs are particular to these specific government healthcare programs, they are similar in that both programs are mandated by federal law to prevent, detect and address fraud, waste and abuse. Part I addresses the Medicare audit components and Part II addresses the Medicaid audit components.

Recovery Audit Contractor (RAC)

What is the RAC program?

The RAC program, rolled out in October 2008, is a CMS program called the national Recovery Audit Contractor (RAC) program. It was authorized by Congress (Medicare Modernization Act Sections 306: Tax Relief and Healthcare Act of 2006- Section 302), to detect and correct past improper Medicare payments (overpayments and underpayments).

- Allows CMS and Carriers/FIs/MACs to implement actions that prevent future improper payments.
 - Providers can avoid submitting claims that don't comply with Medicare rules
 - CMS can lower its error rate
 - Taxpayers and future Medicare beneficiaries are protected
- Affects all providers that bill the Medicare fee-for-service Part A or Part B programs- Inpatient Hospitals, IRFs, SNFs, Hospice, Outpatient Hospital, HH, Physicians, Other Part B Billers (DME, lab)
- Recouped overpayments in the DemoRAC project: 85% from Inpatient Hospitals, 2% from SNFs, remaining other providers

CMS divided the nation into regions A, B, C, D each with its own RAC.

- The RAC is a contracted entity authorized by CMS to identify and recover potential payment errors. The RAC is made up of physicians, nurses, therapists, certified coders. RACs are paid on a contingency fee basis on both the overpayments and underpayments they find.
- RACs perform post-payment reviews, either automated (claims data analysis) or complex (medical record reviews). If the RAC determines an adjustment is required based on

recovery audit findings—i.e. overpayment to the provider, the provider can dispute through an informal discussion (option 1) or through a formal appeals process (option 2).

- Limits on look-back period (3 years/ max date 10-1-2007)
- Appeals is a complex process that can take 12-24 months per claim
- CMS has affected a Phase-In Strategy by review type, not provider types. All provider types are available for RAC review once provider outreach has occurred in the state.
- The map below color codes states for the project and indicates the RAC that will be performing the audits.

Yellow-Green states- *Earliest possible dates for reviews in*

yellow/green states -- Arizona, California, Colorado, Florida, Hawaii, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, and Wyoming

- Automated Review-Black & White Issues (June 2009)
- DRG Validation-complex review (Aug/Sept 2009)
- Complex Review for coding errors (Aug/Sept 2009)
- DME Medical Necessity Reviews-complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

Blue states- *Earliest possible dates for reviews in blue states --*

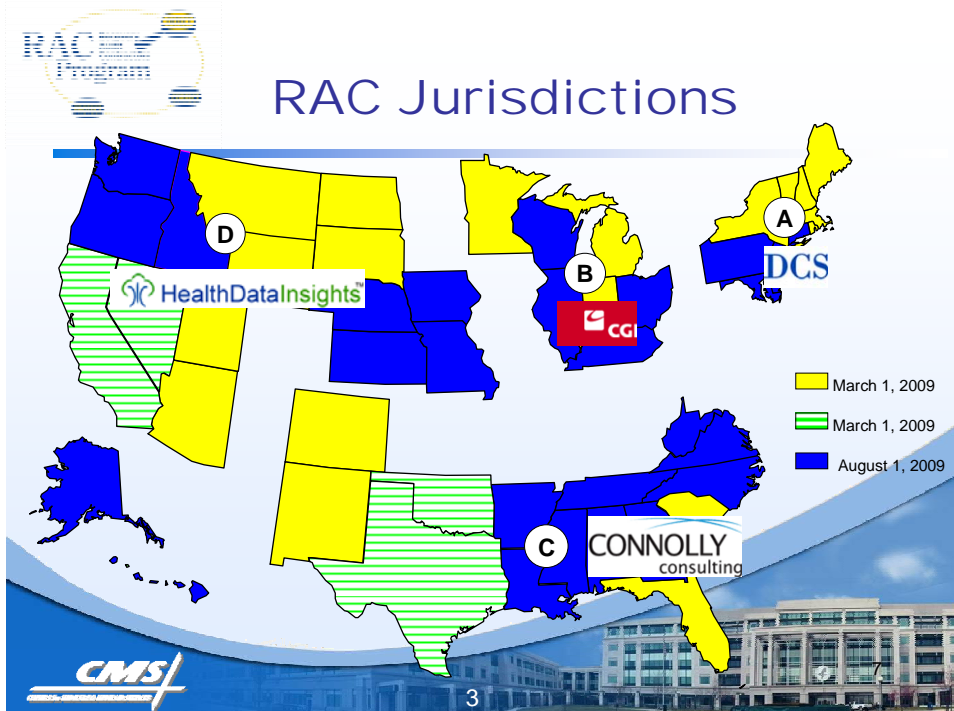
Washington, Oregon, Idaho, Nebraska, Iowa, Missouri, Wisconsin, Illinois, Ohio, Kansas, Arkansas, Alaska, Louisiana, West Virginia, Tennessee, Mississippi, Alabama, Georgia, New Jersey, North Carolina, Virginia, Kentucky, Pennsylvania, Maryland, Delaware, and Connecticut.

- Automated Review-Black & White Issues (August 2009)
- DRG Validation-complex review (Oct/Nov 2009)
- Complex Review for coding errors (Oct/Nov 2009)
- DME Medical Necessity Reviews-complex review (Fiscal year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

What is the impact of RAC audits to the nursing home industry and what can a provider do to prepare?

- CMS recoups improper payments from providers
- The detailed appeals process requires resources from the provider such as attorney fees and internal staff time for preparation and tracking
- Providers should know of any prior improper payments that stemmed from inaccurate billing processes
- Providers should keep/submit proper Medicare documentation Facilities need to ensure thorough and proper documentation for therapy, treatments, clinical conditions, medical necessity etc. (adequate Medicare documentation of services delivered)

- Ensure your facility has a sound MDS data integrity system capable of identifying various inconsistencies related to Medicare billing such as:
 - Conditions related to treatments- i.e. therapy without a related diagnosis, therapy without functional deficits, nursing rehabilitation without clinical symptoms etc.
 - Signs and symptoms related to conditions
 - Clinical and logical inconsistencies- Activities of Daily Living (ADL) coding, mood signs and symptoms coding, and coding related to all sections of MDS
- Providers should review their MDS and care planning processes in an ongoing manner to ensure accuracy
- Ensure your facility has a system in place for auditing Medicare PPS records and billing forms to validate correct MDS coding, clinical conditions and treatments, medical necessity and correct placement into RUG categories
- Ensure your facility's processes for determining residents scale scores in the areas of ADL index, cognitive performance scale and depression scales, which are used in RUG categories, are adequate and consistent
- Ensure staff receives adequate training/education sessions on the RAC process and Medicare documentation (medical necessity etc.)



Important Resources:

CMS information on RACs:

<http://www.cms.hhs.gov/RAC>

http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage

Updated: July 28, 2009 By Jane M. Niemi RN, MSN, NHA Senior HealthCare Specialist