Recovery Audit Contractor Program Is Underway

BY DENISE NAPOLI

WASHINGTON — Physicians and other providers in certain states are beginning to receive demand letters from Medicare Recovery Audit Contractors, Dr. Thomas Valuck said at a meeting of the Practicing Physicians Advisory Council.

Officials from the Centers for Medicare and Medicaid Services will begin to roll out the program to the rest of the country this summer, according to Dr. Valuck, medical officer and senior adviser at the Center for Medicare Management.

The Recovery Audit Contractor (RAC) program is designed to identify and correct past improper Medicare payments, including underpayments. It began as a demonstration project in California, Florida, and New York in 2005, and was made permanent and nationwide in 2006 by the Tax Relief and Healthcare Act. It is administered by private contractors who collect a fee based on the errors they detect.

The RACs—which have access to Medicare fee-for-service claims data—use software to analyze claims for inaccuracies regarding coding, billing, and payment. Beginning in September, the RACs will also conduct computer-facilitated "complex reviews" on diagnosis-related group (DRG) coding errors, according to Cmdr. Marie Casey, USPHS, CMS deputy director of recovery audit operations. And by 2010, in addition to these audits, the RACs will also review the medical necessity of certain claims. These types of reviews will rely on the expert medical opinion of physicians and other medical professionals who work for the RACs. Cmdr. Casey added that the RACs can audit any Medicare fee-for-service claims up to 3 years from the payment date, but during the program's early phase will review only claims made on or after Oct. 1, 2007.

Cmdr. Casey and her colleague Lt. Terrance Lew, USPHS, a health insurance specialist at the division of recovery audit operations at the CMS, offered the following advice for preparing for an RAC review:

► Know where previous improper payments have been found so that you can avoid making the same mistakes.

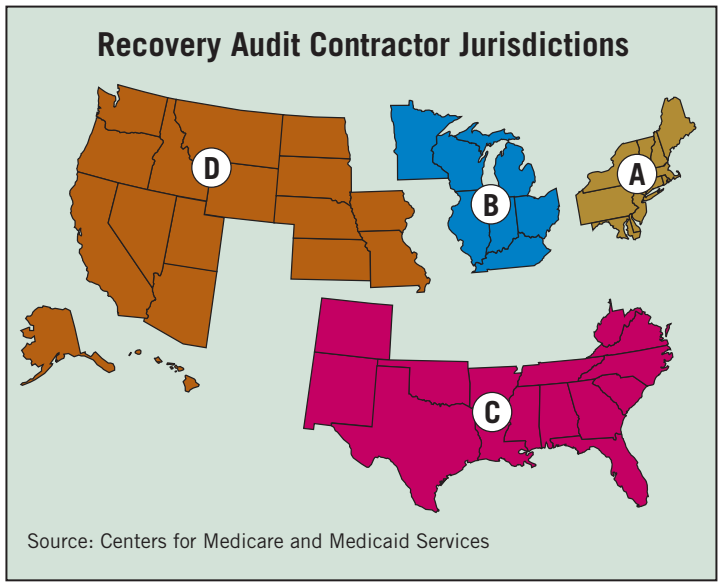
► "Keep a clean shop," Lt. Lew advised. "Make sure that you're in compliance with all the applicable Medicare policies, coverage determinations, coding directives, requirements for documentation."

► Identify key RAC contacts. Each region has its own RAC. (See box.)

► Develop processes for tracking and responding to RAC requests and demand letters. "There are timelines attached to demand letters," Lt. Lew said.

► Appeal when necessary. "If you make a business decision that an appeal is warranted, we would certainly encourage you to appeal," Lt. Lew said. ■

For more information, visit www.cms.hhs.gov/RAC.



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Get Ready for the RAC

Outreach designed to educate providers about the RAC program and what to expect is still being conducted in Regions B and D, and the CMS soon will begin outreach in Region A. The updated provider outreach schedule can be found at www.cms.hhs.gov/rac.

Provider outreach must occur in each state before an RAC is authorized to send any correspondence to a provider, such as a demand letter for recoupment or a request for additional documentation.

The RACs will begin with very basic "black and white" reviews, Cmdr. Casey said, adding that these reviews will be performed on an automated basis (no medical records are required).

Starting as early as September, the RACs may begin reviewing coding issues and diagnosis-related group validations, which will require the review of additional documentation.

Once the RAC has been established in the region, the RAC may begin to review claims for medical necessity.

To contact the RAC for your region:

► **Region A:** Diversified Collection Services (DCS), 1-866-201-0580; www.dcsrac.com.

► **Region B:** CGI, 1-877-316-7222; http://racb.cgi.com; racb@cgi.com.

► **Region C:** Connolly Consulting Inc., 1-866-360-2507; www.connollyhealthcare.com/RAC; RACinfo@connollyhealthcare.com.

► **Region D:** HealthDataInsights Inc., 866-590-5598 (Part A); 866-376-2319 (Part B); racinfo@emailhdi.com.

CMS Reminds Physicians of HIPAA 5010 Format Deadline

BY MARY ELLEN SCHNEIDER

Physicians have a little more than 2 years to complete their transition to new HIPAA X12 standards for submitting administrative transactions electronically, according to Medicare officials.

As of Jan. 1, 2012, physicians and all other entities covered under HIPAA (Health Insurance Portability and Accountability Act) will be required to use the HIPAA X12 version 5010 format when submitting claims, receiving remittances, and sending claim status or eligibility inquiries electronically. The change will affect dealings not only with Medicare, but also with all private payers.

The Medicare fee-for-service program will begin its own system testing next year and will begin accepting administrative transactions using the 5010 version as of Jan. 1, 2011. Throughout 2011, the Centers for Medicare and Medicaid Services will accept both the 5010 and 4010A1 versions. However, beginning on Jan. 1, 2012, only transactions submitted using the 5010 version will be accepted.

During a recent conference call to update providers, officials at the Centers for Medicare and Medicaid Services urged physicians not to wait until the last minute to make the transition to the new format.

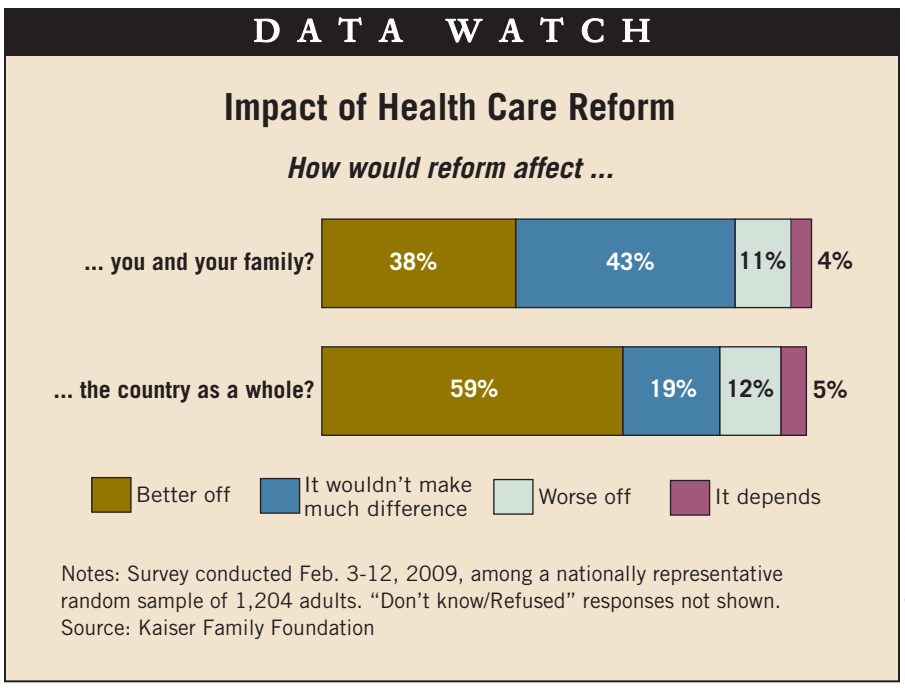
"There's no room to delay. We cannot possibly convert all of the Medicare trading partners at the 11th hour," said Christine Stahlecker, director of the Division of Medicare Billing Procedures in the CMS Office of Information Services.

The switch is necessary, according to the CMS, because the 4010A1 version is outdated. For example, the industry currently relies heavily on companion guides to implement the standards, which limits their value. The new version includes some new functions aimed at improving claims processing, such as resolving ambiguities in the situational rules and providing more consistency across transactions.

But Medicare officials urged physicians to analyze the new version carefully prior to implementation. Billing software will need to be updated, and business processes may need to be changed as well. "There are real changes in these formats," Ms. Stahlecker said.

A comparison of the current and new formats can be viewed online at www.cms.hhs.gov/ElectronicBillingED ITrans/18_5010D0.asp. Another reason that physicians should pay attention to the 5010 transition is that it paves the way for the move from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used to the significantly expanded ICD-10 code sets on Oct. 1, 2013.

Ms. Stahlecker advised physicians to contact their system vendors as soon as possible to find out if their licensing agreement includes regulatory updates and to get the vendor's timeline for upgrading its systems. ■



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