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RAC and CMS Audits: Top Documentation Issues for ASCs and How to Reduce Risk

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RAC Audits were implemented by CMS in 2005 to detect and correct past improper payments made on Medicare claims to help Medicare implement actions to prevent future improper payments. They are meant to discourage providers from submitting claims that do not comply with Medicare rules, help CMS lower its error rate, to help assure Medicare monies are spent correctly and to protect Medicare patients.

RAC audits affect claims for providers filed to Part A and Part B. It has been a VERY successful program in Medicare's eyes, as they had collected approximately $992.7 million in overpayments as of 2009. During the same period, they had only identified $37.8 million in underpayments (which does not appear to be what the RAC auditors focus on). In published statistics from October of 2009 through March 31, 2011, the RACs have identified $312.2 Million in overpayments and $52.6 Million in underpayments. With such great success, Medicare plans on this program to be of great assistance in maintaining the solvency of the Medicare program going forward. What does this mean for Medicare providers? It is time to assess your facility's risk, be proactive and take action to protect yourself. It's not a matter of IF you will be audited by a RAC Contractor – but WHEN!

The RAC audit program has been implemented by steady expansion to perform audits using 4 regional contractors in all 50 states as of January of 2010. The four RAC audit contractors are listed below:

RAC	Website	Telephone Number
Region A: Performant Recovery-CT,DE,DC,ME,MD, MA,NH,NJ,PA,RI & VT	www.Performantrac.com	866-201-0580
Region B: CGI-IL,IN,KY,MI, MN,OH & WI	http://racb.cgi.com	877-316-7222
Region C: Connolly, Inc. AL,AR,CO,FL,GA,LA,MS,NM,NC, OK,SC,TN,TX,VA,WV & PR	www.connollyhealthcare.com/RAC	866-360-2507
Region D:HealthDataInsights AK,AZ,CA,HI,ID,IA,KS,MO,MT,ND, NE,NV,OR,SD,UT,WA & WY	http://racinfo.healthdatainsights.com	Part A: 866-590-5598 Part B: 866-376-2319

The RAC audit contractors are reimbursed on a contingency basis, based on what they find in overpayments from auditing providers. This amount is offset by any underpayments the RAC audit contractors find, however, RAC auditors do not seem to find many underpayments. RAC audits can only go back to dates of service of October 1, 2007.

The overpayments assessed by RAC contractors may involve recoupments being made from provider EOB/RAs before the provider has a chance to work their way through the Medicare appeals process. Demand Letters related to RAC audits come from the RAC contractor and you might notice Medicare Remark Code N432 : Adjustment Based on Recovery Audit on your Medicare EOB.

Types of RAC Audits

1. **Claim RAC Audits**
   Claim RAC audits focus on claims which violate Medicare policies
2. **Medicare Secondary Payor Audits**
   MSP Medicare Secondary Payor RAC audits involve claims made by providers which should have been reimbursed by a different payor.
3. **Automated Audits**
   "Automated" audits are done on an automated basis (using computer system data mining techniques) on what Medicare calls "black and white issues", such as checking the number of units billed on the claim form, duplicate claims, etc. This process involves "assumed" errors.
4. **Complex Audits**
   "Complex audits" involve medical records being manually reviewed by RAC auditors. Complex audits review for coding errors and medical necessity issues. Providers have 45 days to submit documentation to support billings.

5. **Semi-Automated Claims Review**
   This is a hybrid method of automated and complex audits, which has two parts.
   - Automated review of claim data for billing aberrancies with a high likelihood of suspicion for improper payment, which is the data mining process. These identified claims contain "possible" errors, rather than "assumed" errors.
   - Notification letter to the provider about the potential billing error and the provider has 45 days to submit records to support the billed codes.

   Medicare states that the RAC program has Three Keys to Success:

   1. Minimize provider burden
   2. Ensure accuracy
   3. Minimize transparency

RAC Audits can have Devastating Results

RAC audits review claims on a post-payment basis and go by Medicare policies and guidelines. One experienced healthcare auditor states that "adverse findings on RAC audits could impact not only the bottom line of a healthcare provider, but also could result in the facility or physician being reported to licensing boards, regulatory bodies, and also the HIPDB (Healthcare Integrity and Protection Data Bank). Once a provider is reported to the HIPDB, the provider can lose their Medicare provider status, and then private payers may then exclude the provider from their plans." The program is constantly being expanded by the Federal government.

Also, other insurance payors (like Blue Cross/Blue Shield) are ramping up their audit efforts to recover reimbursement from healthcare providers, as well - so it's not just Medicare you have to worry about. It is vitally important to prepare for these types of audits NOW!

Ways to Prepare for RAC Audits

- Have a Compliance Plan which is up-to-date and considered to be "effective" by Medicare.
- Keep up with coding and Medicare rules and guidelines.
- Have regular chart audits done and regular training for staff on ASC coding & billing issues.
- Providers and management must have a commitment to compliance as the corporate culture of the organization.
- Keep track of denied claims and look for patterns.
- Determine what corrective actions you need to take to promote compliance and avoid improper payments.
- When requests for more information come in from Medicare or the RAC contractor, treat them seriously and respond to them according to the timelines requested and respond fully to requests.
- Keep resources (coding books, coding software, etc.) up to date, check CCI edits on Multiple Procedures, etc.
- Keep up with RAC Audit Focus Issues, which are published regularly by the RAC audit contractors.
- Information on the RAC audit program is on the websites of the RAC audit contractors. Medicare's RAC website is: www.cms.gov/RAC.

Provider Options When Dealing with RAC Audits

It IS possible to survive a RAC audit and to work your way through the appeal process and try to get some or all of the money back they are trying to fine you. Don't feel powerless in the process.

When being subjected to a RAC Audit, providers have several options:

- If you agree with the RAC contractor's findings, you can pay the owing amount by check, you can allow Medicare to recoup the owing amount from EOBs for future Medicare payments, or you can request an extended payment plan to reimburse Medicare for the owing amount.
- If you do not agree with the findings of the RAC contractor, you can perform aggressive appeals. You can start by sending a "discussion letter" to the RAC contractor, but you must also file a formal appeal before the 120th day after the date of the RAC's demand letter.

The same 5 levels of Medicare Appeals Process still apply to the RAC audit process, even though the audit was performed by the RAC contractor.

One bit of good news is that if the provider's appeal is successful at any level of appeal, the RAC contractor must return its contingency fee amount to Medicare on those claims.

Medicare's Appeals Process

Medicare's 5 Levels of Appeals are as follows:

1. Redetermination by the Medicare MAC
2. Reconsideration by a QIC
3. Hearing by an Administrative Law Judge (ALJ)
4. Review by Medicare Appeals Council
5. Judicial review in U.S. District Court

RAC Audit Focus Issues

RAC Audit Focus Issues are areas in which Medicare expects RAC reviews to produce violations resulting in refund requests for money back from providers. Focus issues are reviewed and approved by CMS prior to being implemented by RAC contractors. Part B providers need to focus on coding billed, proper modifier usage, medical necessity issues and how they complete their claim forms.

Examples of RAC audit focus issues which ASC facilities can face:

- Untimed Codes – when Part B providers are billing for CPT codes where the procedure is not defined by a specific timeframe, be sure to only list a "1" in the Units column on your claim form.
- Urological Procedure Bundling – pay close attention to CCI Unbundling Edits when billing urology surgical procedures, as Medicare has strict guidelines about use of the -59 Modifier when billing these procedures and trying to bill procedures done in the same area when they are unbundled and not separately billable.

- Using correct Place of Service Codes on claim forms. Be sure the ASC facility AND the physician's bill always use POS Code 24 for ASC facilities when procedures are performed at an ASC facility. When the POS 11 for the physician's office is used on claims when procedures are performed at ASC facilities, the physician is incorrectly reimbursed more for the surgery, which is a compliance issue.
- ASC facilities billing Medicare directly for services provided to patients under care in skilled nursing facilities covered under Part A. The surgery performed in the ASC would be considered bundled services and must be billed to Medicare Part A by the SNF facility in a consolidated bill.
- IV Hydration Therapy – when billing CPT code 96360 for Intravenous infusion, hydration; initial, 31 minutes to 1 hour (previous code was 90760 for dates of service prior to 1/1/09), be sure to only list a "1" in the Units column on your claim form.
- Bronchoscopy procedures – when billing codes 31625, 31628 and 31629, be sure to only list a "1" in the Units column on your claim form.

- Once in a Lifetime Procedures – for those CPT procedures which can only be performed once in a person's lifetime (such as a Hysterectomy), with the exception of codes billed with the -58 Staged Procedure Modifier, when billed more than once will be subject to review.
- Pediatric codes exceeding age parameters. An example would be the "over 12" or "under 12" year old distinctions on the Tonsillectomy codes.
- Global vs. TC/26 Modifiers on X-rays and other services with split components – be sure when billing for any service that can be billed with the Technical Component (–TC Modifier) for the equipment ownership and supplying the staff to do the test and the Professional Component (-26 Modifier) for the physician or other provider doing the interpretation and report of the service that the appropriate Modifiers are appended to the CPT codes. When billing the CPT code with NO MODIFIER, you are billing Globally for both the Professional Component and Technical Components of the test.
- Incorrect billing of Bilateral Procedures – which involves both incorrect modifier usage and billing in a bilateral manner for procedures which are inherently bilateral and should not be billed in a bilateral manner (i.e., code 30802 for Cauterization of Turbinates, Laparoscopic Tubal Sterilization procedures, Tonsillectomy procedures, etc.).

- Medically Unlikely Edit List. Medically Unlikely Edits (MUE) were developed by CMS in 2007 to assure that the maximum number of units of a service for a CPT/HCPCS code that would be billed by a provider for a single patient on one date of service is not violated. Not all CPT or HCPCS codes have an MUE assigned, but those which do have this type of edit assigned will deny if the number of units requirement is violated.
- Degenerative Nervous System Disorders – which may involve Pain Management Injection procedures.
- Esophagitis and other miscellaneous digestive disorders - which may involve GI Scope procedures.
- Medical Necessity Issues.
- Percutaneous Cardiac Procedures - if your facility performs Pacemaker Insertions or Cardioversion procedures.

- Other Vascular Procedures – which may involve placement of ports for IV Therapy and/or Varicose Vein procedures.
- Kidney and Urinary Tract Infection diagnoses – which may involve Urology surgical procedures.
- Facility vs. Non-Facility Reimbursement – Place of Service errors on claim forms – be sure if physicians perform surgery at the ASC facility to use POS 24 code as the Place of Service on claims, rather than POS 11 for the physician's office. If surgical procedures are performed at the physician's office, they are reimbursed at a higher rate than when they are performed at the hospital or ASC, which is fraud issue.
- Anesthesia Care Package and E&M Services – Anesthesiology services include an E&M component of assessing the patient for anesthesia the day before and day of the surgery, so no separate E&M code should be billed unless it is unrelated to the anesthesia for the procedure.

- NCCI Edit Violations – while some CPT codes are billable using a -59 Modifier when they are unbundled in the CCI Edits because they were performed at a different site or organ system, performed though a separate incision/excision, performed in a separate compartment, involved a separate lesion, etc., those procedures which are unbundled and are not allowed to be billed with the -59 Modifier are a focus issue.
- Billing Colonoscopy procedures with excess units on claim forms.
- Tracheostomy procedures.
- Billing Cataract Extraction procedures with excess units on claim forms.
- Excisional Debridement procedures.
- Add-on CPT Codes – when secondary Add-on Codes are billed without the required primary procedure being billed.

- Filing Duplicate Claims on the same services to Medicare.
- Patient Date of Death issues – billing claims for dates of service after a Medicare patient's date of death.

It is important to understand that once a provider has gone through a RAC audit, it does not mean that the same provider will never again have to endure a future RAC audit. ALL providers are subject to RAC audits going forward, and if your facility performs a procedure which is becomes a RAC audit focus issue, you may have to go through another RAC audit for that particular issue/denial reason.

CMS data from March of 2010 reveals that 64% of appealed claims had a decision in the provider's favor. Doing appeals is definitely worth the hassle and the time. Be aware of Medicare Local Coverage Determination (LCD) policies pertaining to procedures performed in your ASC facility and be sure the first diagnosis billed on Medicare claims is listed on the LCD for that procedure. Referencing these policies works in your favor when performing appeals of denied claims and appeals of RAC audits. Also defend Medical Necessity of procedures with the help of the operating physician to justify their intent and why the procedure was necessary to perform for the patient.

Now is the time to prepare and make sure your facility is doing things right – before Medicare RAC auditors do it for you and try to take back your hard-earned money!

Top Documentation Issues for ASCs

Documentation issues can affect ASC billing & coding in a significant manner.

- Vague OP Reports can cause underbilling of procedures.
- "Canned" OP Reports can be a compliance issue and a malpractice issue.

Documentation Issues

- No OP Report within 30 days can lead to payors recouping money on the case.
- Chronic documentation issues can cause significant coding mistakes.

Purpose of Medical Record Documentation

- Medical records should detail information pertinent to the surgery performed.
- Support the medical necessity of the surgical procedure(s) performed and billed.
- Serve as a legal document describing the patient's treatment in the ASC facility.

Purpose of Medical Record Documentation

- The medical record must support the Medical Necessity of the CPT & Diagnosis codes billed.
- All entries in the medical record must be dated with a full date (Month/Day/Year) and should be signed by all physicians and nurses recording in the record.
- Patient's name and/or Medical Record Number should be on *every page* in the patient's chart.
- The medical record should be complete and legible with entries made in black ink.

Incomplete OP Reports and OP Report Addendums

- OP Report Addendums – Addendums should be dated with the date Addendum is done.
- State it is an "Addendum".
- Addendums can be done on the original OP Report or on a separate piece of paper.

Incomplete OP Reports and OP Report Addendums

- If done on a separate piece of paper, document date of original procedure and the procedure performed.
- Do not re-type OP Reports as a new original document.
- Addendums can be handwritten by the surgeon or typed.
- Addendums must be signed by the surgeon.

Issues with "Canned" OP Reports

- Medicare compliance issues with "Cloned Records"
- "Canned" OP Reports may not contain all of the information necessary for proper documentation of the procedure performed.
- Reports may have no Pre- or Post-operative diagnosis tailored to the patient.
- The report may be missing essential language tailored to that patient's surgery.

"Canned" OP Reports

- Report may not list the procedure performed and/or indicate upon which side (Left or Right) procedure was performed.
- Can cause the ASC to have to refund money.
- Can cause an issue with the facility's state survey.
- Can be a potential malpractice issue for both the surgeon and the facility.

OP Report Requirements

- OP Reports must be tailored enough *to each individual surgery* and circumstances for use, and not appear to be "canned".
- Any deviations from normal during surgery, (complication or a change in something just in that patient's procedure, etc.) must be correctly documented in the OP Report.
- If the report is not accurate, detailed and individualized, it can be a compliance issue.

Place of Service Issues on OP Reports

- It can cause problems when physicians dictate OP Reports off-site from the ASC facility.
- OP Reports dictated off-site can make it appear the procedure was performed at a hospital or physician's office, with the ASC not indicated as where the surgery was performed anywhere on the report.
- It is insufficient for the ASC facility to only be listed as "cc: XYZ Surgery Center" at the end of the OP Report.

Place of Service Issues

- The ASC could be charged with filing a false and/or fraudulent claim, due to it not being clear the procedure was performed at your ASC facility.
- **It MUST be very clear on every OP Report that the procedure was performed at your surgery center.**
- Be sure all surgeons operating at your facility use Place of Service (POS) code 24 on the physician claim when billing for their services, rather than POS 11 for their office – this is a serious Fraud issue with Medicare claims.

Timeliness of OP Reports

- Be sure each service billed is properly documented PRIOR to billing it.
- Medicare expects OP Reports to be complete and in the patient record within 30 days of the procedure.
- There are financial, as well as compliance consequences, to slow/late dictation.
- Make SURE the **original** OP Report for cases is kept in your ASC's chart – it is NOT to be kept at the surgeon's office.

Medical Record Errors

- Be sure errors are corrected properly in the medical record.
- Be sure Errors in OP Reports are corrected before the surgeon signs the report and makes it a permanent part of the medical record.
- Never scratch out Errors in medical records.

Medical Record Errors

- Do not use “white-out” on errors in medical records.
- Correct errors in medical records by making a *single line* through the error (in ink), write the word “Error” above it, make the correction, and initial the change.
- Never alter a medical record in an improper manner.

Other Medical Record Issues

- OP Reports must be dated with the surgery date. When using forms for the OP Report, be sure there is a blank prompting the surgeon the document the actual surgery date, as required, and that all blanks are completed.
- Using the facility sticker or stamper on documents is not a sufficient way to document the date that document was completed (particularly on H&Ps and OP Reports).

Other Medical Record Issues

- Make sure physicians complete all blanks in OP Reports and other documentation.
- Physicians are responsible for all information in transcribed OP Reports, H&Ps, etc. being correct.
- Using stamps or phrasing such as “dictated but not read”, does not relieve the physician of responsibility for the documentation being correct.

Signature Stamps

Medicare rules are that physicians are not to use signature stamps to sign their OP Reports, H&Ps or any other medical record documentation. If you have physicians who are still using signature stamps, you need to discontinue this practice at your ASC. Use of electronic signatures on the computer and in EMRs are acceptable.

Questions ?

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