Doctor Perspectives

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Editor: Maureen West McCarthy, CPA

RAC Audits: The Best Offense Is Knowledge And Preparation

By Linda Casey, CPC - Senior Healthcare Consultant, SCCH Healthcare Division

CMS has developed a phase-in strategy for RAC audits and they have already begun in a number of states. In 2010, this will expand to include all 50 states. The onset of these audits has increased fear and worry in the provider community. However, we believe the best offense is to educate healthcare providers and their staff about RAC audits, and inform them how to prepare for a potential RAC audit.

The Facts

The purpose of the RAC audits is to identify both overpayments and underpayments, collect or refund any identified incorrect payments, and help avoid the same type of errors going forward. RAC contractors will receive payment on a contingency basis, based on their findings, on both overpayments and underpayments. CMS has defined areas where the RAC contractor may audit for improper payments, which include:

- Incorrect Payment Amounts (based on the published CMS fee schedule)
- Non-Covered Services, including Medical Necessity
- Incorrectly Coded Services (This includes DRGs)
- Duplicate Services

It is important to note that the RAC auditors are excluded from pursuing improper payments in some cases. While not limited to the list below, here are some of the exclusions:

- Claims that are 3 years past the date of initial determination (this date is defined as the claim paid date.)
- Any claim paid prior to October 1, 2007
- Claims on Prepayment Review – RAC auditors may only identify incorrect payments using post payment review.

RAC contractors may not review claims already under review by another CMS entity or law enforcement agency. To ensure this, a master table will be maintained listing excluded providers and claims that the RAC contractor must check before initiating an audit. In addition, any claim that has been previously reviewed, including appealed claims are excluded from audit.

There will be two types of RAC audits, an automated review and a complex review. In the automated review, there is no review of the medical record and it is limited to coverage/coding determinations that include both the following:

- A certainty that the service was incorrectly coded or was not a covered service
- A *written* Medicare policy, article or approved coding guideline exists

RAC Audits, continued on page 2

Will Consult Codes Be Abolished as of 1/1/10?

By Maureen West McCarthy, CPA, Director, SCCH Healthcare Consulting Division

If the current proposed Medicare rule goes through, as of January 1, 2010, CMS will abolish the Consultation codes all together, except for the telehealth consultation "G" codes. The targeted CPT codes 99241-99245 (Office) and 99251-99255 (Hospital) are codes that have been on the OIG Hit List for many years, and are primarily used by specialist physicians, but in some cases are utilized by primary care physicians as well. CMS states that the abolishment of the Consultation codes will be done in a "budget neutral" fashion, neither decreasing or increasing total expenditures. They expect to realize this by including in the proposal an increase in the reimbursements on the New Patient codes and Established Patient codes. Currently the suggested projection is that the office based E&M codes will increase 6% and the hospital E&M visits will increase 2%. We do not believe this will be enough to offset the loss of the consult codes for many specialties.

Consult Codes, continued on page 3

RAC Audits, continued from page 1

The second form of RAC audit is a complex review, which includes a request and review of the medical documentation. During the review process, an RN or therapist will be required to review the record for medical necessity and a certified coder will be required to determine if the claim was correctly coded. Remember the following if your practice receives a request for medical records:

- The RAC contractor is required to explain the "good cause" for reopening a claim, i.e. OIG report findings, data analysis findings, comparative billing analysis, etc.
- If the RAC auditor comes to the office and requests to inspect the records, the practice does not have to allow them on-site, and the Contractor cannot make a determination of overpayment based on the fact that they were not allowed on-site, but must instead, follow-up with a written request for the medical records.
- The provider will have 45 days to respond to the request for medical records. If they do not respond within this time frame, the RAC contractor will be allowed to determine that the claim was overpaid after making one additional contact for the records.
- There is a limit on the number of medical record requests that can be made, based on the type of provider (Facility, Physician, DME, Lab, Outpatient facility) and the size of the practice.

RAC auditors have 60 days in which to complete their complex reviews and may only extend that with a waiver granted by CMS.

If an automated review has been performed, the RAC contractor is only responsible for notifying the provider in the event an overpayment occurred and is required to include which coverage, coding, or payment policy was not met.

On complex reviews, the RAC contractor is responsible for responding on each review completed for both positive and negative results, and in the case of a negative finding, they must include what policy the denial is based on.

There are three primary reasons for a negative determination:

1. It is a non-covered service (including but not limited to, excluded service, not medically reasonable, an experimental service, too frequent a service, etc.).
2. The service was incorrectly coded or fails to meet National and Local Coverage Determinations.
3. Was incorrectly paid, either due to being a duplicate payment, paid at an incorrect rate, or was subject to multiple procedure reimbursement.

However, the RAC contractor is prohibited from making denials based on minor omissions such as missing dates or signatures.

On full denials, the RAC contractor will request the amount of overpayment on behalf of the appropriate CMS intermediary. On partial denials, if a portion of the claim is payable, the claim will first be reprocessed by CMS, and only the difference will be requested back.

If a determination of overpayment has been made, the provider has several options:

1. If the practice disagrees with the findings, they can follow the normal appeal process, and recoupment will be delayed until the appeal process is complete. Please remember specific timeframes will apply, and if lost on appeal, the balance due will be subject to interest.
2. Pay the balance by check.
3. Allow the balance to be paid by offsetting future payments.
4. File appropriate paperwork to arrange a payment plan.
5. Propose a settlement amount. The RAC contractor does not have the authority to negotiate a settlement but they will forward the request to CMS. It is important to note that specific documentation will be required and if the amount is over $100K the request must include a completed Claims Collection Litigation Report.

Preparation – What Can You Do?

In the current climate, it is important to take a proactive approach and we recommend the following actions:

1. **Identify** areas of focus where your practice might be open to risk and look at previous targeted areas identified by RACs. These can be found at the CMS website *www.cms.hhs.gov/rac*, under Demonstration findings. In addition, you can log on to the RAC contractor web sites (links to these can be found on the CMS web site) and look at their findings.
2. **Review** the OIG reports and CERT reports to identify other areas of concerns.
   OIG: *www.oig.hhs.gov/reports.html*
   CERT reports: *www.cms.hhs.gov/cert*
3. **Perform** an external *baseline* chart audit by a reputable medical chart auditor to ensure correct coding and compliance issues are being met.
4. **Monitor** claim denials to identify trends and patterns, and if appropriate appeal denials.
5. **Develop** Corrective Action Plans for any errors identified and monitor compliance closely.
6. **Attend** a CMS Provider Outreach program; look for one in your area to attend.

If you do receive a RAC Medical Record Request be sure to do the following:

1. Register with your RAC contractor and inform them who the contact person is in the office and the address of where Medical Record requests should be sent.
2. Send records by certified, return receipt mail to ensure that they are received within the 45 day timeframe.
3. If you have questions, you may contact the RAC contractor. Check their web site for their customer service phone numbers and call.

If you receive an unfavorable determination and you disagree with the findings, take the following steps:

1. Notify the RAC contractor, in writing, that you disagree with their findings and why.
2. Begin the appropriate appeals process, making sure to file within the specified time frames, and monitoring closely that your CMS contractor adheres to their timeframes for response.

If you agree with the findings and need to refund overpayments, review your options for repayment and follow the appropriate steps.

Snyder Cohn has expertise in performing external baseline audits and working with practices to establish and implement processes for internal audits, once the initial external audit is completed. In addition, Snyder Cohn has worked with practices going through both CERT education and RAC audits. We will work through your attorney to offer you the best legal protection. Please contact Maureen McCarthy, CPA at 301-652-6708 ext. 333 for additional information or if you need immediate assistance due to the receipt of a RAC medical record request or CERT letter.

Consult Codes, continued from page 1

Snyder Cohn has prepared an analysis to illustrate how the loss of the Consult codes for a specialist physician might affect a physician's revenue even if additional monies are allocated to the other E&M services.

The assumptions for this illustration are that a specialist who performs approximately 500 consults a year (10 per week) and has a normal distribution curve would see the following result to their revenue.

As you can see, with these assumptions, even with the proposed increase to the reimbursements for the New Patient and Established Patient codes, a specialist with these frequencies would experience a $23,650 loss to their top line for the same amount of work annually.

We are publishing this information now before the final decision has been made to inform you about the possible loss of the Consultation codes and to encourage you to contact your political representatives, both in government as well as at your specialty societies, medical societies, and the AMA to let them know that it is imperative that they consider this major change carefully and that they must increase the replacement codes to the correct payment level to avoid physicians losing money due to this change.

2009 DC Medicare
PAR/Non-facility setting

# of Visits	Office Visits	Current Allowable	With 6% Increase	Office Consults	Current Allowable	Variance $	Net Loss
28	99201	$ 41.83	$ 44.34	99241	$ 55.02	$ 10.68	$ 299.04
56	99202	$ 71.55	$ 75.84	99242	$ 101.77	$ 25.93	$ 1,452.08
112	99203	$ 103.15	$ 109.34	99243	$ 139.53	$ 30.19	$ 3,381.28
84	99204	$ 157.65	$ 167.11	99244	$ 204.78	$ 37.67	$ 3,164.28
55	99205	$ 198.38	$ 210.28	99245	$ 251.22	$ 40.94	$ 2,251.70
30	99212	$ 42.27	$ 44.81	99242	$ 101.77	$ 56.96	$ 1,708.80
60	99213	$ 68.80	$ 72.93	99243	$ 139.53	$ 66.60	$ 3,996.00
45	99214	$ 103.37	$ 109.57	99244	$ 204.78	$ 95.21	$ 4,284.45
30	99215	$ 139.12	$ 147.47	99245	$ 251.22	$ 103.75	$ 3,112.50
						Total Estimated Loss	$ 23,650.13

Please do not hesitate to contact us if you have additional information we can share with our readers or if you have specific questions. Contact Maureen McCarthy, CPA at 301-652-6708 et. 333.

Summary of the Proposed 2010 Medicare Physician Fee Schedule

On July 13, 2009, CMS published the proposed 2010 Physician Fee Schedule in the *Federal Register* which includes proposed Medicare payment rates and policy changes. They have also published an impact chart which shows the effects of the proposed rule on each medical specialty, and a table which shows the effects on selected HCPCS codes.

Payments to Physicians Fee Schedule (PFS)

- CMS is proposing an increase in payment for the Initial Preventative Physical Examination (IPPE), "Welcome to Medicare" exam, beginning January 1, 2010. The current code, G0344, has a work RVU of 1.34 and the new code, G0402, will be given a work RVU of 2.30.

- Updates and revisions to the work, practice expense and malpractice RVU's will impact various specialties, some positively, others negatively. Among the winners, with the following estimated increases:
  – Ophthalmology +11%
  – Physical/ Occupational Therapy +10%
  – Family Practice and Geriatrics +8%.

  The losers, with the following estimated cuts:
  – Diagnostic Testing Facilities -24%
  – Radiation Oncology -19%
  – Nuclear Medicine -13%.

- CMS is proposing to redefine "Physicians' Services" to remove the physician-administered drugs component from the SGR (sustainable growth rate) formula. This proposal would remove drugs from the SGR calculations beginning in 2010. This will not affect the estimated 21.5% decrease for 2010, but rather would reduce the number of years providers would experience further decreases (At press time, this issue continues to be strongly debated).

PQRI

- The incentive payment for 2010 will be equal to 2% of the estimated total allowed

Fee Schedule, continued on page 4

charges of all covered professional services provided during the reporting period for successful participants.

- Group practices, defined as 200 or more individual eligible professionals who have reassigned billing rights to the group TIN, will also be eligible to receive the 2.0% incentive payment. Interested groups will be required to submit a self nomination letter to CMS. The Physicians participating in the group practice reporting option will not be eligible to participate separately as an individual.

- As long as the Electronic Health Record 2009 testing is acceptable, CMS is proposing to accept data from a qualified EHR product along with the claims-based and registry-based reporting mechanisms.

- They are proposing to retire 7 of the 2009 PQRI measures and add 22 new measures. For details go to *http://www.cms.hhs.gov/PQRI/02_Spotlight.asp#TopOfPage*

E-Prescribing

- Even if your practice cannot qualify for PQRI, you may still be eligible for E-Prescribing incentives. In 2010, the successful E-Prescribers incentive payment will be 2%. For complete details go to *http://www.cms.hhs.gov/ERXincentive/*

Advanced Diagnostic Imaging Suppliers

- Beginning January 1, 2012, CMS will only pay for TC services to accredited suppliers including mobile units, physicians' offices, and independent diagnostic testing facilities that create the images. This accreditation requirement does not apply to the physician who interprets the studies.

- The accrediting organization will also have ongoing responsibilities monitoring the supplier to ensure that they meet defined standards including maintaining a quality control program of the equipment that ensures both quality of the diagnostic images and that the equipment meets performance specifications. In addition the accrediting agency will also ensure the supplier meets personnel safety standards.

- Currently it is assumed that a physician uses their equipment about 50% of the available time. A recent survey showed that this equipment is being used more often resulting in a reduction of costs incurred by the provider in operating, maintaining and purchasing this equipment. Therefore, CMS is proposing that the utilization rate be changed to reflect the true costs.

Upcoming Seminars

9/23 ***It's All About the Revenue***
ES MGMA, Salisbury, MD

10/29 ***Profit Center Accounting to Ensure/Measure Success***
MCMS Retreat,
Potomac, MD

11/5 ***How Can You Qualify for EMR Stimulus Money***
Snyder Cohn, Bethesda, MD

11/17 ***Year End Tax Planning & Pension Plan Primer***
MCMS Administrator Roundtable, Rockville, MD

Please contact Jane Thomson at 301-652-6708 ext. 361 if you are interested in attending any of these seminars.

National News

CMS

Medicare Payments Subject to Withholding Due to Federal Payment Levy Program

Since October 1, 2008, CMS has been authorized to collect unpaid taxes for the IRS by offsetting your Medicare payments. Starting October 1, 2009, CMS will also be authorized to collect non-tax debts owed to other Federal Agencies, i.e. educational loans, by offsetting your Medicare payments. If you have questions regarding offsets due to a tax-related debt, you must contact the IRS, and for non-tax debt, you must contact the Treasury Department's Financial Management Service. For complete details go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6228.pdf*

CMS Prepares for Flu Season

CMS will be reimbursing for the H1N1 vaccine administration similar to the way they reimburse for the seasonal flu vaccine (for specifics, go to FAQ section n the link below). In addition, they have issued guidelines in the event of a pandemic flu outbreak. For complete details go to *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp.*

In related news, effective October 1st, 2009 there will be a new ICD 9 code for the H1N1 virus, code 488.1. The development of this code, which normally would have been reviewed by March to be effective October 1st, was fast tracked once the virus was identified in April to enable the CDC to better monitor and track the H1N1 virus.

Errors Will Not be Reimbursed

Effective January 15, 2009, Medicare will no longer pay for services when a provider incorrectly performs a surgery or procedure on a patient. These "Never Events" include: 1) the wrong surgery or invasive procedure performed on a patient, 2) a surgery or procedure performed on the wrong body part or 3) a surgery or procedure performed on the wrong patient. The procedure or patient is considered incorrect if it does not match the patient's correctly documented informed consent. Medicare will also not cover the hospitalization or other services associated with the erroneous procedure. Complete details are located at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf.* (Note: Effective August 15, 2009, Aetna is also no longer paying claims on Never Events.)

ASC Payment Changes Enter Third Year

CMS has been implementing a new payment system for Ambulatory Surgery Centers (ASCs) over a four year period. 2010 is the third year of this implementation, with 75% of payments being based on the new payment system. Furthermore, ASC's will also be eligible for inflationary adjustments, which may increase payments. See the July 1, 2009 fact sheet at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp* for more details.

Proposed Changes to the Physician Fee Schedule for 2010 Announced

The annual fee adjustments, which are required by Medicare law, had been scheduled to be negative for the past several years. Congress prevented the reductions from taking effect for the years 2004–2009. 2010 is projected to have a rate reduction of 21.5%. In addition, CMS has proposed that Consultation codes no longer be reimbursed, forcing providers to use the remaining E&M codes for those visits. A final rule is expected by November 1, 2009. See the July 1, 2009 press release at *http://www.cms.hhs.gov/apps/media/press_releases.asp* for more details.

Proposed Changes to the Physician Quality Reporting Initiative and E-Prescribing Incentive Program for 2010 Announced

Proposed changes for PQRI include the addition of new reporting measures, the determination of qualification based on the group practice level (vs. the individual level), and the addition of electronic health record (EHR) reporting for certain PQRI measures. Proposed changes regarding the reporting requirements for the e-prescribing incentive program are aimed at simplifying the process. Remember, beginning in 2012, all e-prescribers must be deemed "successful electronic prescribers" in order to avoid penalties. For more information on these changes, see the July 1, 2009 fact sheet at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*

Physician Orders for Diagnostic Testing

CERT errors resulting from the lack of documentation related to the ordering of diagnostic tests appear to be on the increase. Acceptable forms of communication orders to testing facilities include written orders signed by the provider, e-mails, or telephone calls. PLEASE NOTE: Telephone calls must be documented in the patient's medical record by both parties. It is important to include such orders with any medical record request. Additional information can be found on the CMS Internet Only Manual: PUB 100-2, Chapter 15, Section 80.6.1.

New Billing Requirements for DMEPOS Suppliers

Effective January 4, 2010, DMEPOS suppliers can only bill for services that are ordered by an eligible provider who is enrolled in the Provider Enrollment, Chain and Ownership System (PECOS). Claims submitted must contain the ordering provider's name and National Provider Identifier (NPI). The ordering provider's eligibility will be verified in PECOS before a claim is paid. Orders must also be fully documented in the patient's medical record. Providers can verify their enrollment in PECOS at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*

New Disclosure Requirements for Physician-Owned Hospitals

Effective June 9, 2009, hospitals that are physician owned are required to disclose the names of the physician owners to their patients. Furthermore, physicians who refer patients to a hospital in which they hold an interest (either ownership or investment) must disclose that interest to their patients. Immediate family members of the physicians who also hold such interests must be disclosed as well.

OIG

OIG's semiannual report listed expected recoveries at $2.4 billion for the first half of the fiscal year. The recoveries came from a variety of sources, including four states.

As a result of concerns over improper service billing by nonphysicians, the OIG has requested that CMS review its incident-to policies. The OIG is seeking revisions to the policies that will help to ensure that services are only performed (or personally supervised) by licensed physicians and that a modifier be used to identify those services that are supervised. It is also requesting that CMS take action against claims that are billed incorrectly.

The OIG is also recommending that CMS take steps to address the appropriate billing for chemotherapy administration services. Findings have shown that payments have been made for such services on days when no drugs (or nonqualifying drugs) were billed. The report is titled "Medicare Part B Chemotherapy Administration: Payment and Policy" and is available on the OIG website (*www.oig.hhs.gov*).

Other News

Red Flag Rules Delayed Again

The FTC (Federal Trade Commission) has further delayed the compliance date of the Red Flags Rule until **November 1, 2009**. Go to the FTC's Red Flags website, *http://www.ftc.gov/redflagsrule* to obtain information on creating your practice's compliance program.

Cigna

Beginning July 24, 2009, Cigna's Customer Call Centers will be open 24 hours a day, 7 days per week for their customers and healthcare professionals. Cigna's provider website, *www.cignaforhcp.com*, is available for pre-certifications Monday through Saturday from 7am to 12 midnight and Sunday from 2pm to 7pm ET.

Cigna now offers a Cost of Care Estimator to assist providers in discussions with patients about the financial details pertaining to their care. The estimator is currently available for professional and outpatient services performed in all settings. It will be available for inpatient facility services in the coming months. The estimator will help members understand their treatment costs, including the amounts that will be paid by Cigna as well as their own out-of-pocket costs. This can be calculated prior to rendering the services, so patients can be fully informed of their financial responsibility. The Estimator can be accessed by logging on to the Cigna for Health Care Professionals website at *www.cignaforhcp.com*. Click on 'Estimate Patient Liability', and you will be guided through the process.

Effective January 1, 2010, Cigna will move its clearinghouse connectivity for EDI transactions from Emdeon to Ingenix. If you currently use Emdeon for your EDI transactions, please contact either Post-N-Track at *www.Post-N-Track.com* or (860) 257-2030 or Ingenix at *www.ingenix.com/connectivity* or (877) 380-7515 prior to the January 1st transition to ensure your EDI connectivity is not interrupted.

Local News

Maryland

New Maryland Law for Insurers Regarding Electronic Health Records

A new Maryland law will require private insurance companies to offer financial incentives to providers who switch from paper-based to electronic medical records. The bill will allow the carriers to choose the type of incentive they will offer. Possibilities include increased reimbursements, lump-sum payments, or in-kind services. Officials believe that this will assist in motivating providers to implement EMR in their practices. CareFirst has already chosen to offer increased reimbursements to providers using EMR.

All Areas

CareFirst

Starting January 1, 2010, BlueLink, CareFirst's bi-monthly newsletter, will only be available on-line. You can be notified via e-mail when new additions become available. The newsletters can be accessed by visiting *www.carefirst.com/providers*.

CareFirst Direct has implemented new security measures. Two auto purge rules are now in effect: User ID's that have been disabled for 90 days will be deleted, and Users that have not logged in for 180 days will be deleted. New User ID's will be needed in both of these instances.

An updated CareFirst Blue Choice in-office procedure list can be found in the benefits section of the CareFirst provider's manual. To access the provider manual, go to *www.carefirst.com*, click on Providers & Physicians - Solution Center - Provider Manuals.

Highmark

Effective immediately, requests for immediate offsets for overpayments must be submitted by fax to (717) 302-3823. Highmark will no longer accept these requests by telephone.

In an effort to lower the error rate in the J-12 Region (which includes the state of Maryland, the District of Columbia, the city of Alexandria, and the Virginia counties of Arlington and Fairfax), the CERT Program will be focused on an increased number of audits for the following codes:

- Office E&M Codes – Levels 4 and 5
- Consult Codes – Levels 4 and 5
- Hospital Codes – 99233 and 99239

Help SCCH Go Green:

Starting 2010, we will offer our newsletter electronically. To update our current mailing list and to join our preferred electronic mailing list, please email the following information to Melissa Linkins at: *linkinsm@cpahelp.com*.

We will need:

- **Practice Name**
- **Contact Name**
- **Email Address**
- **Practice Address**
- **Phone**
- **Fax**

Thank You

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