

Recovery Audit Contractor (RAC) Presentation
Program Review and Update
November 18, 2009

Note: The content of this presentation posted is compiled from notes taken during the AMCNO Third Party Payor Seminar on November 18, 2009. These notes should be viewed along with the CGI and CMS slide presentations as background. The notes should not be relied upon as the only source of information regarding the RAC information presented. Please utilize and rely on the web site resources contained in the notes and the slide presentations for additional background.

Centers for Medicare and Medicaid Services (CMS)

Presenters: Scott Wakefield, CMS Project Officer, RAC Region B
Patricia Rosinski, RN, Nurse Consultant, CMS, Provider Compliance Group

(Slide 1) The first presenter was Scott Wakefield who shared that CMS will give an update on the RAC program and acknowledged that some people may already have had RAC 101. CGI then will give a breakdown of what they are looking at and contact information for the provider community.

(Slide 2) Agenda: we will look at the current status of the RAC program – outreach and program specifics and new issues for the review, continuing to prepare for the RAC introduction.

(Slide 3) The Tax Relief and Health Care Act of 2006 (TRCA) required a permanent and nationwide RAC program by January, 2010. The provider outreach has been completed now in every state. All RACs have CMS history data going back to 2007 and all states are now eligible for review.

(Slides 4-5) The RAC outreach schedule was shown and an idea of where CMS has done provider outreach for the provider community.

(Slide 6) CMS did a 3-year RAC demonstration from 2005-2008 in California, New York and Florida. They learned some lessons from these demonstrations that were incorporated into the national program. These include:

- The look-back period for the RAC is now a 3-year period.
- RACs are now allowed to review claims in the current year which they could not do during the demonstration.
- RACs must have on staff a fulltime medical director or CMD and an alternate, and certified coders, essentially having the same staff that will mirror those in the provider community so that their RAC recommendations can be based on expert backgrounds.
- The RAC process allows for a discussion period, which is an unofficial time when a provider can contact the RAC and discuss the determination with them.

- Providers now are able to call the RAC and get the credentials of the reviewers.
- Vulnerability reporting now is mandatory for the RACs. This is a big change – during the demonstration, if the RACs were overturned on appeal at the first level, they did not have to return the contingency fee. Going forward with the national program, if a provider appeals a RAC determination and it is waived in favor of the provider during the appeals process, the RAC must return the contingency fee. This will help give the RACs more incentive (on top of the contingency fee) to make the correct determination.
- Another change by January 1, 2010, is a statement of work must have a web-based application that allows providers to customize address and contact information. This is important to both the provider community and the RAC in order to get information back and forth such as request letters for additional documentation, letters for overpayment demand, or other items, i.e. this will allow the RACs to know where to reach you.
- An external validation process includes a RAC validation contractor who will look at a sample of each RAC's claims and give them what amounts to a grade or report card annually. That error rate will be published so that providers will have an idea of how the RACs are performing. The RAC validation contractor also will look at new issues submitted by the RAC to CMS for review.

(Slide 7) How does a RAC review a claim? These are some hypothetical figures that we threw together just to show you how the claims data that the RAC receives from CMS flows down. In this scenario, they start with 100,000 claims received from CMS. When they get the claims data from CMS, they run that through a proprietary algorithm based on CMS policy and manuals. Issues that the RAC will review then are formulated from running this data through these algorithms. If they start with 100,000 claims as shown in this scenario, they may be down to 25,000 claims after they run them through the algorithms, which then becomes the focus of a widespread review.

Of these 25,000 claims, they then will run them through an internal system for suppressions and exclusions. How this works is there is a RAC data warehouse where all RAC reviewed claims are housed, i.e. a central repository. Outside Medicare review entities like QIOs, claims processing contractors FIs or MACs, program safeguard contractors (PSC), and some federal law enforcement agencies all have access to this data warehouse and when a claim is reviewed by an outside program contractor, they can exclude their data from the RAC data warehouse so the RACs cannot look at that particular claim. The whole notion behind this is CMS wants the RACs not to request a medical record a second time once it has been requested by another Medicare review entity. Thus when a program safeguard contractor reviews the claim, they enter exclusion into the RAC data warehouse so when the RAC puts a request into the data warehouse, the claim is excluded and will not be reviewed again.

If you get a request for a medical record from a RAC that already has been reviewed by a QIO, a MAC or a PSC, tell the RAC that it was already reviewed and CMS has instructed them to remove that contract from review.

Once the RACs run their universe of claims through the RAC data warehouse for suppressions and exclusions, the number of actual RAC claims could end up at 750 claims. This is a rough scenario of how it works.

(Slide 8) During the RAC outreach events, CMS heard concerns from providers about whether or not the RACs would target providers based on data analysis or certain provider types. The answer is they will not – the RACs are issue driven and they are not looking at specific provider types, but rather they are looking to formulate issues once they have validated a potential vulnerability in a particular area of Medicare billing. Once this is determined, they send the issue to the CMS RAC New Issues Board consisting of policy experts, clinical experts, a medical director and several other entities within CMS. This board looks at the issue and determines if it is valid and either approves or disapproves the issue to the RAC. Once the issue is approved, they post it on the RAC web site and it then can be reviewed from the time of posting. Regions A, B, C and D will submit their own respective issues.

(Slide 9) Patricia Rosinski then spoke about the RAC review process, explaining that RACs review claims on a post-payment basis and use the same Medicare policies as carriers FIs and MACs. These include national coverage determinations and local coverage determinations.

There are two types of reviews: 1.) Automated: these are black and white issues; no additional medical documentation is needed. 2.) Complex: additional documentation is always required.

RACs cannot review claims prior to October, 2007. The maximum look-back period is three (3) years – this is different from the original RAC demonstration, which was four (4) years.

RACs are required to employ a staff consisting of nurses or therapists, certified coders and a physician CMD. In the former program, a contracted medical director was not mandatory.

(Slide 10) What is different from other post payment reviews? 1.) A demand letter is issued by the RAC. 2.) The RAC will offer the provider an opportunity to discuss the improper payment determination with the RAC during a discussion period that is outside of the normal appeal process and is from the date of the demand period through the 41st day. When the money is recouped for complex reviews, it will be from the day of the results letter to when the money is taken. 3.) The issues reviewed by the RAC will

be approved by CMS prior to widespread review. These approved issues will then be posted to a RAC website before widespread review.

New issues will be sent for review to the CMS New Issues Board made up of subject matter experts. If they are approved by this board, then the RACS will be able to do a widespread review.

(Slide 11) A phase-in map was displayed; all the states are now done.

(Slide 12) The CMS RAC review phase-in strategy was shared, focusing on the strategy for blue states since Ohio is a blue state:

- 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)

Phase-in strategy for other states:

- Automated Review – black & white issues (June 2009)
- DRG Validation – complex review (Aug/Sep 2009)
- Complex Review for coding errors (Aug/Sep 2009)
- DME Medical Necessity Reviews – complex reviews (Fiscal year 2010)
- Medical Necessity Reviews – Complex review (Calendar year 2010)

(Slides 13 & 14) Scott Wakefield began again sharing the summary of additional documentation request limits and explained that CMS would like providers to have the slides addressing the documentation request limits for reference; however, he noted that some changes to these request limits are now taking place and there may be changes – so what you see on these slides may not be the documentation request limits in a week or two. CMS has been working with AHA and AMA to look at these limits and further reduce burdens to the provider with some other options for formulating these limits. One of the things they will soon implement is the use of the TAX ID number vs. the individual NPI numbers. Although you have these limits, they probably will change soon. Providers were encouraged to check www.cms.hhs.gov/rac for not only an update to the original documentation request limits, but also for other important information.

Request limits shown:

- Inpatient Hospital, IRF, SNF, Hospice – 10% of the average monthly Medicare claims (max 200) per 45 days per NPI
- Other Part A Billers (HH) – 1% of the average monthly Medicare episodes of care (max 200) per 45 days per NPI
- Physicians (including podiatrists, chiropractors)
 - Sole practitioner: 10 medical records per 45 days per group NPI
 - Partnership 2-5 individuals: 20 medical records per 45 days per group NPI

- Group 6-15 individuals: 30 medical records per 45 days per group NPI
- Large Group 16+ individuals: 50 medical records per 45 days per group NPI
- Other Part B Billers (DME, Lab, Outpatient hospitals) – 1% of the average monthly Medicare services (max 200) per NPI per 45 days

(Slide 15) Patty Rosinski began again by explaining the collection process, which is the same for Carrier, FI and MAC identified overpayments. Carriers, FIs and MACs will issue remittance advice using code N432 “Adjustment based on recovery audit”. The N432 code will be on the remittance advice note when an overpayment is identified and the adjustment is sent forward from the RAC to the claims processing contractor, but there are changes that need to be made in the claims processing system to allow for that code to reflect on the remittance claims notice. While working to place the N432 on the remittance claims notice, we ran into some difficulty, so initially you may have a RAC audit where overpayment determinations are made and you may not see the N432 code, meaning you may have to track it back to the overpayment review letter from the RAC. If providers have questions, they were asked to send them to Scott Wakefield.

Carrier FI and MAC recoups will be offset unless the provider has submitted a check or valid appeal.

(Slide 16) What about rebilling? Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services listed in the Benefit Policy manual. That list can be found at: <http://www.cms/hhs.gov/manuals/Downloads/bp102c06.pdf>

Rebiling for any service will only be allowed if all claims processing and timeliness rules are met. The normal timely filing rules can be found at: <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

(Slide 17) RACs want to maximize transparency. They will do this and major findings will be posted to the RAC claims web site by 2010 and you can follow status of the claim on this website. A detailed review results letter will be sent out following all complex reviews.

(Slide 18) There are some new issues that have been approved; some were in the demonstration process and some were not.

- Region A: Diversified Collection Services (DCS) – www.dcsrac.com (Provider Portal/Issues Under Review)
- **Region B: CGI Federal** – <http://racb.cgi.com> (Issues)
- Region C: Connolly Healthcare – www.connollyhealthcare.com/RAC (Approved Issues)
- Region D: HealthDataInsights (HDI) – <http://racinfo.healthdatainsights.com> (New Issues)

(Slide 19) Some new issues are as follows:

- Pharmacy supply and dispensing fees
- Wheelchair bundling
- Urological bundling
- Blood transfusions
- Bronchoscopy services
- IV-Hydration
- Neulasta (Pegfilgrastim)
- Once in the lifetime procedures
- Untimed codes
- Clinical social worker (CSW) services
- Knee Orthotic bundling

(Slide 20) An example of a new issue posting is as follows:

Issue Name: Wheelchair bundling

Description: Bundling guidelines for wheelchair bases and options/accessories indicate certain procedure codes are part of other procedure codes and, as a result, are not separately payable.

Provider Type Affected: DME

Date of Service: 10/01/2007 – Open

States Affected: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

Additional Information: Additional information can be found in the following manuals/publications:

http://www.cms.hhs.gov/mcd/viewarticle_pdf.asp?article_id=20284&article_version=32&contractor_id=140

(Slide 21) Prepare for the RACs: Are you ready? First, you need to know where your previous improper payments have been found. You can look it up on the CMS website and look up the reports. Second, you need to know if you are submitting claims with improper payments and finally, you need to respond to the RACs medical records requests. It was stated that it cannot be emphasized enough that providers need to have one contact person for the RAC to send information to and a designated address to be sure they get correct correspondence, and also to ensure they have proper identification and contact information.

(Slide 22) It is important to know if you are submitting claims with improper payments. Conduct an internal assessment to identify if you are in compliance with Medicare rule and if necessary, then identify corrective actions to implement for compliance.

(Slide 23) Provider self disclosures: If a provider does a self-audit and identifies improper payments, the provider should report the improper payments to their claims

processing contractor. If the claims processing contractor agrees they are improper, the claims will be adjusted and no longer available for RAC review (for that issue).

(Slide 24) You need to appeal when necessary. We do not go extensively into the appeal process; we are not the subject matter experts on appeal. If you have any questions we cannot answer, you can send us the questions and we will get them to the right people. We have been asked several times about the appeals process and the appeals process is not going to change from what you are familiar with when appealing a claim or overpayment determination made by a FI carrier or a MAC. The appeal stays the same with the exception of the implementation 935, which does affect the recoupment process. There is an article on the website on MLN that deals with the 935. You will want to take a look at that. We are not the foremost experts on that, but we do have people that can answer questions for you on this issue.

(Slide 25) RAC Contact Information contains information on Region B. If you have questions you can send them to the email or look on the site for more information.

- Region A: Diversified Collection Services (DCS)
 - www.dcsrac.com
 - info@dcsrac.com
- **Region B: CGI Federal**
 - <http://racb.cgi.com>
 - racb@cgi.com
- Region C: Connolly Healthcare
 - www.connollyhealthcare.com/RAC
 - RACinfor@connollyhealthcare.com
- Region D: HealthDataInsights (HDI)
 - <https://racinfo.healthdatainsights.com>
 - racinfo@emailhdi.com

(Slide 26) CMS Contact Information includes the RAC web site: www.cms.hhs.gov/RAC On the RAC web site they have RAC demonstration and permanent RAC information. There also is a CMS RAC email address: RAC@cms.hhs.gov. If there are any questions that you do not get answered today, send them to the rAC email and we will get an answer to you in the next couple of weeks.

CGI - RAC Region B Outreach

Presenters: Rob Rolf, CGI Vice President
Mary Hoffman, CGI RAC Project Director
Dr. Percival Seaward, CGI Contractor Medical Director

Mary Hoffman began the CGI portion of the presentation saying it was a pleasure to be with everyone and explaining that this program is built on transparency. CGI is pleased

to announce that they have completed over 65 outreach sessions. CGI wants to be sure that everyone has a good understanding of the program.

(Slide 2) Ms. Hoffman stated they would have brief introductions and would talk about CGI's mission and staff credentials – keys to the RAC program success, the process for review and recovery, and contact information. They also would have a Q and A session at the end.

(Slides 3 and 4) Rob Rolf went over the names and titles of the staff, including Dr. Percival Seaward, the chief medical director (CMD). He explained that they get graded by their clients and their goal is to represent CMS well so the CGI mission is the same as the CMS mission to identify overpayment and underpayments and collection of the same. CGI RAC Mission: CGI's mission for the RAC Region B is to identify improper payments through the detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments utilizing their Customized Auditing Software (CAS) 5.0 software.

(Slide 5) The statement of work required: we have a credentialed team to perform the review. CGI always has had a certified team. We have background in clinical coding and healthcare. We have certified doctors, coding specialists, registered health information technicians, registered nurses, professional coders and registered pharmacist. Whatever expertise we need to perform a good quality review CGI is committed to having those staff on board.

(Slides 6 and 7) Dr. Seaward then spoke about CMD responsibilities. He thanked the AMCNO for inviting CGI to this teleconference to present some of the information on the responsibility of CMDs for the Region B project and said he hoped that it will alleviate concerns and apprehensions. He explained that he is the CMD for RAC Region B and is a board certified general surgeon in active clinical practice before coming to CGI. Dr. Seaward explained he has been with CGI for more than 12 years and currently is based in Cleveland.

Why must there be a CMD? During the RAC demonstration project, providers felt that the lack of a physician presence at the RAC equated to claims being erroneously denied. What happened next then is CMS implemented a change to the RAC program, namely that each RAC had to hire a MD to oversee the medical review process to assist nurses, therapists and certified coders upon request, to manage procedures, and to inform provider organizations about the RAC program to be sure providers know how and why the RAC program will effect them.

What then are the CMD responsibilities?

- The CMD is expected to have an understanding of NCD, LCD and other Medicare policies – providing clinical expertise and judgment.
- Source of Medical Information

- Readily available; the RAC staff must always have easy access to the regional CMD. They must be able to walk into the CMD's office or call when they need information. The CMD must be able to eliminate as many gray areas as possible from the auditing process.
- Questionable claim review situations; the CMD must be able to make decisions on questionable decisions and must be available for one-on-one discussions with physicians. Remember – discuss before you appeal – you may not have to appeal.
- RAC Vulnerabilities Recommendations – this entails the review of known vulnerabilities and other issues.
 - Revision of or introduction to Medicare Claim system
 - Other corrective actions
 - Recommendations related to NCD, LCD, system edits or provider education
- Claim Adjudication briefing and Advising of Personnel
 - Correct policy applications – use of written guidelines

The CMD must review corrective actions and recommend provider education if necessary. The CMD will be involved in claim adjudication briefings which mean discussion with relevant personnel in the review process. The last few requirements noted above ensure the need for CGI to use well recognized and acceptable sources such as CPT ICD 9 CM or coding clinic or CPT advisories. Some of our decisions may be from credible sources in medical literature.

- CME
 - Keeping abreast of current medical practice and technology
 - Applying this knowledge to possible effects on improper payments and abuse
- Interaction – Problem Sharing
 - CMDs are expected to interact with CMDs in other RAC regions

Dr. Seaward said they are encouraged to be working with the RACs and other clinical work groups and providing input into national coverage and payment policy.

- Participation in RAC CMD Clinical workgroups
- Input into National Coverage and Payment Policy, including RVU assignments if requested
- Participation in CMS/RAC presentations to provider and other associations.

The final responsibility of the CMD is to be part of these outreach presentations. This allows the provider organization opportunities to meet and interact with key CMS personnel and also to ask and hopefully get answers to their questions, and to get updated periodically and see that CMS and the RAC contractors are being as transparent as possible.

Dr. Seaward explained they want to be sure that they are operating on valid regulations and current medical knowledge. He intends to ensure that our auditors have up to the minute knowledge to ensure correct auditing. CGI will attempt to apply their clinical judgment to ensure that they are fair, based on good cause and can be supported by acceptable medical practice guidelines. Based on this criteria, we hope that our reviews will more than likely be correct and not overturned on appeals. Remember that we do not want too many of our denials overturned on appeal. The RAC validations contractor will be watching our auditing and reporting back to CMS, so we too are under the microscope. I hope that you will accept us and remember in the long run, we can benefit from this program by preventing overpayments and underpayments.

(Slide 8) Dr. Seaward then turned the presentation over to the other presenters from CGI. Keys to RAC Program Success: Our directive from CMS is to remain transparent. You will always know how we are doing by the status of the review, the coding clinics, the detailed rationale for our decisions, and the rationale we used to identify improper payment. We are approachable and reasonable. We welcome the opportunity to collaborate with you. Let's take advantage of the discussion period. We believe that together we can make good decisions.

CGI's approach to achieving the three keys to its success includes:

1. Maximize transparency through communication. First it's **our web site**. If you do not know anything about the RAC program, visit our web site. Anything you want to know about the RAC you can find there. We have links to the CMS web site. A copy of our letter is posted there; the envelope will be posted there. The web site address is <http://RACB.CGI.com>.

We also have a **call center**. I guarantee you will be greeted by a pleasant customer service representative. We take pride in what we do and the service that we provide. Only the friendliest of the RAC program go through the training. You are guaranteed to get a response within 24 hours of your request.

We have an **email** and encourage your point-of-contact person to use it. We will send all correspondence to this one point-of-contact. You also can use the email to send a question or concern that you may have. If we do not have the answer, we have an excellent relationship with CMS. We have weekly meetings with them and all questions will get an answer. The email address is racb@cgi.com.

The call center phone number is 877-316-racb or 877-316-7222.

Finally we agreed to establish and maintain relations with any associations. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has reached out to us and we will continue to foster our relationship. If at any time the AMCNO has questions, they can contact me and we can setup a conference call, so your association is a key contact – we will send emails to them and will keep the lines

of communication open. So if the above three (3) keys to successful communication fail (i.e. web site, email and call center), contact the AMCNO and ask for assistance.

2. Ensure accuracy. Our staff is credentialed and we will use the expertise of our staff to make decisions. We understand providers want to get it right the first time. We ask two (2) questions: Is it true? And, can it stand an appeal? If we consider it a gray area, we will not pursue that issue.

There are the RAC validation contractors (RVC) – the external validation process – and we want to get a good grade. CMS has the new issue review process to ensure accuracy. They want to be sure the RACs have a good understanding of procedures and guidelines. We have to send a new issue packet to CMS for approval. CMS has nurses, physicians, and certified coders on staff. They will review the issue and if they feel we do not have a good understand of the policy or are misapplying the policy or procedure, we cannot move forward. Only those approved by CMS will be on the web site. Currently there are six (6) posted on the site.

3. Minimize provider burden. CMS has implemented an additional documentation limit. There will be revisions to those limits, but they were put in place with the providers in mind. We want to be sure that we minimize the burden with an enormous amount of medical records request. We utilize our CAS 5.0 software and record our audit findings, and the date we request and receive the medical record. In January 2010, this information will be posted on our web site.

(Slide 9) There are two types of reviews: Complex and Automated. Complex requires a medical record; automated does not require a medical record.

- Complex Review Steps and Tracking
 - Auditors will select cases for review and request the medical record; the request date and the requesting auditor is automatically recorded in CAS.
 - Medical record is received in CAS 5.0, and the received date is automatically recorded.
 - Auditor reviews the medical record and documents audit comments in CAS 5.0; the date is recorded in CAS 5.0. This is a way to give the provider customer service; if you call us and give us the name of the patient, you will be directed to the appropriate person so you can get an answer.
 - The physician's comments are also documented in CAS 5.0; the date is recorded in CAS 5.0 automatically.
- Automated Review
 - Occurs when a RAC makes a claim determination at the system level without a human review of the medical record. When you look at the web site and the six (6) issues are automated, these are issues that we can

make a determination that a service is not covered or incorrectly coded or supported by Medicare policy or coding guidelines.

- Coverage/coding determinations are made through automated review.
- The RAC may use automated review when making coverage and coding determinations only where BOTH of the following conditions apply:
 - there is certainty that the service is not covered or is incorrectly coded, AND
 - a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline (e.g. CPT statement, CPT assistant statement, coding clinic statement, etc.) exists.

For automated reviews, these are black and white issues such as duplicate claims or pricing mistakes. These errors do not have a policy or a guideline to support it; you could detect it by looking at the claim.

- The RAC may use automated review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often don't exist for these situations.

(Slide 12) A second goal is to identify underpayments. CGI receives the same contingency fee for over and under payments. It does not make a difference because we are contracted to review both. We can identify them at the line level. If it was billed at a low level of payment but should have been a high level of payment, the RAC will make sure the claim is adjusted accordingly.

For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment group (e.g. APC, RUG) on a claim that were billed at a low level of payment, but should have been billed at a higher level of payment. The RAC will include review for underpayments as a part of our auditing process.

- Upon identification, the RAC will communicate the underpayment finding to the appropriate affiliated contractor.
- Neither the RAC nor the AC may ask the provider to correct and resubmit the claim.
- The affiliated contractor validates the underpayment occurrence, adjusts the claim and pays the provider.
- The RAC will issue a written notice to the provider, via the Underpayment Notification Letter.
- Provider inquiries are answered by the RAC call center.

(Slide 13) CGI contact information was provided again.

Call Center for RACB - Toll free: 877-316-RACB

E-mail: RACB@cgi.com

Web site: <http://RACB.CGI.com>

I sincerely appreciate the opportunity to present the RAC program to you and look forward to working with you.

Question and Answer Period

Facilitated by: AMCNO President Anthony Bacevice, Jr., M.D.

Q1. *It has been stated that the RAC audit can go back for three (3) years, but the timely filing limit in our state is one year. Is there not a discrepancy on how far back one can go and how far back the RAC audit can go – one year?*

A1. CMS is aware of that discrepancy. It has been mentioned in every outreach event to the extent that the other project officers were bringing that concern back to CMS. Because it is a policy issue and RACs do not establish their own policy, it needs to go up to the congressional level. We encourage providers to contact their congressman and local representatives and express your concerns. During the demonstration period CMS was allowed to waive the timely filing limits. Now we have to stick to statutes so the timely filing limits are in place. Policy is established starting at the congressional level on down, so write your congressman and let them know.

Q2. *Since it appears the Medicare provider is changing in Ohio, will there not be a delay of implementation of RACs in this region.*

A2. This is a question about the implementation of the MACs once those awards are made. They are under a corrective action plan now and because of the nature of contractual things at CMS, I cannot predict when that will be resolved. Though once they are resolved and the MAC is decided, if the entity that is awarded the contract carries the current workload Part A or Part B, there will be no blackout period; but, if a new contractor is chosen to take the workload, then there is a 6-month blackout period – 3 months before and 3 months after the cutover date. What this means for physicians is if there is a blackout period and it is in place, the RACs cannot send out demand letters or over-documentation letters in that 6-month period. After that period expires though, the RACs may go back and look at claims within that 6-month period.

Q3. *The media seems to be focusing on the money loss of DME vs. smaller providers. Are the RACs going to be focusing more on high-end potential problems vs. small office?*

A3. Good point. When the RACs do their data analysis it is done at a high level. They do not target specific providers or provider types, but we know that there are specific vulnerabilities in the Medicare program and some of those point to specific provider types. So the RACs conduct a broad-based review. They look at OIG reports, comprehensive CMS reports and the media to see what is out there. They get their ideas from those types of sources and if I were a provider, those would be the areas I would take a close look at. So keep checking the web site because every new issue will

be on our web site and going forward, you can check to see if the issues affect your provider type.

Q4. *Discovery of underpayment – can you please go over this again, the process and consequence if within an audit a service is undercoded?*

A4. If the service was undercoded, it is pretty much the same as what you are used to currently with underpayments. In the course of their review, if the RAC determines an underpayment has been made, the FI or carrier will be responsible for returning that money and making the provider whole. If CGI comes across an underpayment, one of the questions we receive is: "As a provider, do I need to rebill or send in a corrective bill?" The answer is NO. You will receive a letter from us indicating that we identified an underpayment and information from the FI carrier. We will notify the FI carrier of the underpayment and they will process the corrected adjustment and be responsible for paying out the additional dollars.

This is a good point to raise. Improper payments are both under and over payments and the contingency fee, which is a big point of contention with the RAC program so we are told, is the same whether RACs recover over or under payments.

CMS is telling the RACs to go forward at a measured pace and to utilize transparency as we go forward. They want the provider community to be sure of what is going on as we move forward. CGI will stay in touch with the provider community after these events. We want to remain in contact. To that end I would encourage you to email the RAC with your questions. If you do have questions, you can email me direct: scott.wakefield@cms.hhs.gov. You could also send them to the CMS address, but they will probably come back to me anyway, so it would be easier to just send them directly to me.

Q5. *What does CGI stand for?*

A5. CGI stands for Counselors to Government and Industry. We stand for quality. Some 25 years ago, we shortened our name to CGI.

Q6. *If an error in billing or coding is found and it results in an overpayment, what is the next process in recovering the cost?*

A6. If there is an improper payment or overpayment in an automated review, you would receive much the same as the current process with FI, which is an overpayment demand letter from the RAC along with a remittance advise notice from the claims coding contractor. You would have a standard period of time for appealing if you do not agree with that determination. You may also choose to pay back the overpayment by check since it could be recouped by an offset and all of these have further implications in the appeals process. It is the same as an FI carrier determined overpayment.

Q7. *If there are coding questions, can they contact you for that?*

A7. I would recommend if you have coding or clinical questions that you go to the FI

carrier or MAC because they are the ones responsible for educating the provider community. Our role is auditing what is submitted; the remainder is with the carrier and who advised them.

Q8. *Is CGI publicly or privately owned?*

A8. It is a publicly traded company on the NYSE.

Q9. *If we get a request for an audit and looking at the claim we realize we made a clerical error, is there a way to contact the RAC during the discussion period?*

A9. Yes, you can call the RAC immediately. We've touched on the unofficial discussion period. It does not circumvent or halt the appeals process, but yes, if you see something in your billing and receive an overpayment determination from the RAC, contact them immediately and talk with them about it.

Dr. Bacevice concluded by saying on behalf of the AMCNO and those in the audience, we thank the presenters today from CMS and CGI for their participation. It was very enlightening since we are going forward with this new initiative. As well, we appreciate your points about transparency. Thank you.