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CMS Lays Out RAC Changes That Will Occur When Program Resumes

CMS' planned changes to Recovery Audit Contractor efforts, which will be implemented when the program kicks into gear with new contractors, are viewed by some provider groups as a step in the right direction, but the American Hospital Association says the proposed reforms do not address many of the problems caused by the RACs and continues to seek legislation revamping the program.

When the RAC reviews resume under the new contracts, CMS said it plans to implement five changes in response to concerns from RAC stakeholders. "The CMS is confident that these changes will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency," CMS says on its website.

The five changes in a nutshell: require RACs to wait 30 days before sending a claim to Medicare administrative contractors; require RACs to confirm they have received a receipt of discussion requests within three days; require RACs to wait until a decision is reached at the second level of appeal, the Qualified Independent Contractor, before they receive their contingency fee; establish revised additional documentation request limits; and require the auditors to adjust the ADR request limits by the providers' denial rates.

The changes will go into effect when new contractors are chosen. CMS on Wednesday (Feb. 19) announced the RAC program would begin winding down at the end of the month to make for an easy transition between contractors. The American Health Care Association said the pause was a good decision by CMS. AHCA President Mark Parkinson added, "This 'RA pause' is a welcomed next step in the long term and post-acute care community's goal of timely and appropriate initial Medicare claim processing and early appeal decisions. There needs to be fewer inaccurate Medicare contractor audits, and claims appeals need to flow on a faster timetable in order for the process to work."

A spokesperson for the American Coalition for Healthcare Claims Integrity, which represents RACs said that while the group supports CMS' efforts to improve and refine the RAC program, "the changes to the RAC payment schedule will not yield tangible improvements to the Medicare oversight process." The law says RACs should be paid when the federal government is paid, the spokesperson said, and delaying payment will not impact how the RACs operate or the amount they recover.

"The changes are small steps toward addressing significant hospital concerns with the administrative burden caused by the RAC program, but do not address lengthy delays in the RAC appeals process or discourage RACs from making inappropriate denials in the first place," AHA told members in *AHA News*.

AHA had previously suggested that CMS suspend the RAC program until the backlog at the third level of appeals is resolved.

AHA says it plans to continue pushing CMS to address its other concerns. The hospitals also plan to urge lawmakers to pass the Medicare Audit Improvement Act, which calls for other RAC reforms.

CMS says its proposal to require that RACs wait 30 days to allow for a discussion before sending the claim to the MAC for adjustment will mean providers won't have to choose between initiating a discussion and an appeal. RACs also will be required to confirm they have received a receipt of discussion requests within three days.

AHCA officials said this is a welcome improvement and could help avoid appeals upfront, while the pause itself helps solve the backlog of appeals at the third level of the appeals system, as new appeals will not be bumping into what's already waiting.

Paula Sanders, an attorney with Post and Schell, said that CMS' proposed change is progress and the discussion period could help avoid appeals over technical denials, but only if the 30-day discussion period is meaningful. The only way to make sure such a discussion period is useful is to add quality metrics and accountability to the program, Sanders said.

Under the new contracts, RACs also will be required to wait until the second level of the appeal, the Qualified

Independent Contractor level, makes a decision before they can receive their contingency fee. RACs currently receive their contingency fees after recoupment of improper payments, even in cases where providers appeal the denial. Stakeholders say the shift is a step in the right direction, and will provide increased accountability in the long run.

CMS also plans to establish revised additional documentation request limits. The ADRs are currently based on entire facilities, not different departments within a hospital or provider facility. CMS plans to create ADR limits across different claim types, establishing different limits for inpatient, outpatient and other types of requests.

Auditors will be required to adjust the ADR limits by the providers' denial rates, so that providers with low denial rates will have lower ADR limits than those with higher denial rates.

AHCA officials said a concern is different RACs deny claims at different rates, which could disadvantage some providers simply due to which RAC they work with. Officials suggested a proportional denial rate within each RAC, not a national denial rate, might be used to decide the new ADR limits.

Sanders said that while new ADR limits for the RACs are a sign of progress, providers are often dealing with ADRs from multiple contractors at the same time. An overall limit, not just a limit on the RACs, is necessary moving forward, she said. — *Michelle M. Stein*