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**RE: *Recovery Audit Contractor (RAC) Request for Proposal (RFP)*
*RFP-CMS-2007-0022***

This document serves as an addendum to the American Hospital Association's October 26 comment letter to the Center for Medicare & Medicaid Services (CMS) on the recovery audit contractor (RAC) program. If you have any questions about our comments or this technical addendum, please contact Don May, vice president for policy, at 202-626-2356 or dmay@aha.org.

SPECIFIC COMMENTS AND QUESTIONS ON THE RAC STATEMENT OF WORK

I. Purpose.

Paragraph 2. (Page 1) This section states that, “*underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act.*” This section should also reference processing of underpayments. The second sentence in paragraph 2 should read: “The identification and communication of underpayments and overpayments and the recoupment of overpayments and repayment of underpayments will occur for claims...”

Item 1. (Page 1) This section states: “*Identifying Medicare claims that contain non-MSP underpayments for which payment was made under part A or B of title XVIII of the Social Security Act...*” However, this sentence should include processing of underpayments and, thus, should state: “Identifying and processing Medicare claims that contain non-MSP underpayments...”

Note. (Page 1) The note pertains to the education function of CMS contractors. In the Statement of Work, CMS has tasked Quality Improvement Organizations (QIOs) to provide proactive education. However, CMS moved review and education



responsibilities from the QIOs to the fiscal intermediaries (FIs) in another action.

III. Transition from Outgoing RAC to Incoming RAC. (Page 2)

Paragraph 2. (Page 2) The AHA recommends that CMS include hospitals, hospital associations and other Medicare contractors as “affected parties” for communication of the transition plan in the demonstration states. CMS also should clarify the process in areas where there is an existing RAC that is transitioning to a new RAC contractor. If it is known a change in contractor will be taking place, CMS should establish a close-out period 60 days prior to end of the contract during which the outgoing contractor may not make requests for new medical records and instead focus on processing and completing all claims previously requested. In addition, the outgoing contractor should be required to share provider contact information with the new RAC.

Task 1 – General Requirements. (Page 3)

A.1. Project Plan. (Page 3) It is our understanding that extrapolation is not appropriate for RAC use since reviews are not based on a random selection of claims (the only purpose for which is establishing an error rate), and RACs are not tasked for provider education. Section 935(a) of *The Medicare Modernization Act of 2003* (MMA) and Section 30.10.1.2 of the *Program Integrity Manual* require that, before extrapolation can be used to determine overpayment amounts to be recouped, there must be a determination of *sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error*. Reference to extrapolation in this section should be removed.

A.2. Provider Outreach Plan Section. (Page 4) CMS should require RACs to conduct initial educational sessions with state hospital, nursing home and medical professional associations on behalf of providers.

B. Monthly Conference Calls Section. (Page 4) CMS should require RACs to have ongoing monthly calls with state hospital, medical and nursing home associations (as well as others, as appropriate) to discuss issues of concern to the provider community.

C. Monthly Progress Reports. (Page 4-5) This Statement of Work includes increased reporting requirements for the RACs, including twice monthly conference calls (rather than once monthly) and monthly reports to include specific information. The AHA requests that these reporting requirements be expanded to ensure improved oversight from CMS, including monitoring of the contractor compliance with Medicare policies governing medical necessity. In addition, CMS should require that providers have access to these progress reports.

We further recommend that the monthly progress reports should include separate reports on: (1) the number of medical records requested from provider; and (2) number of records that were processed within the timely processing time frame. CMS and providers

should know when the RACs are having difficulties processing records within the 60-day time frame identified in the *Medicare Program Integrity Manual* (Section 3.413).

Task 2 – Identification of Non-MSP Overpayments. (Page 6)

B. Non-MSP Improper payments EXCLUDED from this Statement of Work. (Page 7) This section used to exclude evaluation and management services (E&M) from RAC review, as was done in the RAC demonstration program. However, this Statement of Work does not exclude E&M services. The AHA recommends that CMS exclude all E&M coding from RAC review because there are currently no national E&M coding guidelines for hospitals under the outpatient prospective payment system.

B.2. Cost report settlement process. (Page 7) This section does not appear to be complete. CMS should add “or any other cost report settlement issue” to this section.

B.5. Random selection of claims. (Page 8) Current law and Medicare policy allows extrapolation for recouping overpayments only when there is evidence of a sustained or high level of error, or when there is documentation that educational intervention has failed to correct the payment error. Therefore, we conclude that RACs cannot use extrapolation since CMS prohibits RACs from randomly selecting claims, an approach that is used to establish an error rate. We recommend that the Statement of Work state that the RACs may not use extrapolation.

D. Obtaining and Storing Medical Records for non-MSP reviews.

D. Paragraph 4. (Page 11) This paragraph indicates that CMS has the discretion to institute a medical record request limit. The AHA strongly recommends that CMS prospectively impose a medical record request limit on the RACs. Such a limit should be scaled based upon the number of Medicare hospital admissions or discharges, and should be capped at a maximum of 50 records requested per provider per month for providers doing the most Medicare business.

D.1. Paying for Medical Records. (Page 11) The Statement of Work should identify a specific time frame by which the RAC must pay for copies once the invoice is received. CMS also should clarify that the RAC will be required to pay the hospital or its copying service. The Statement of Work also should address an automatic change in the payment rate if the federal rate changes over time.

RACs should be encouraged to immediately accept imaged or electronic medical records from providers, claim clearinghouses and medical record clearinghouses. If they cannot do so when they first get the contract, CMS should set out a set period of time by which they must be able to accept these.

D. 2. Second Paragraph Communication and Correspondence with Provider-Database section. (Page 12) The AHA appreciates and supports such provider surveys.

We recommend that CMS share the results with the health care community regularly. For all the reasons CMS notes in this section, we urge CMS to make the use of an electronic database mandatory, rather than just encouraged. Further, the listing should be due to CMS more frequently than twice a year. We recommend quarterly.

D. 3. Assessing an overpayment for failing to provide requested medical record. (Page 12-13) Communication through the regular mail is unreliable, with lost and misdirected correspondence a frequent problem. Therefore, if communication with the provider is not done electronically, the RAC should be required to initiate one additional communication either via phone or in writing before a denial is issued for failure to submit a medical record.

However, as we recommended earlier, CMS should establish an electronic platform that would allow providers, the RAC and FI to actively track the status of claims being processed for review, as well as medical record requests.

D. 4. Bullet 4 Storing and sharing medical records. (Page 13) We urge CMS to require RACs to make the status of all requested medical records continuously available to providers through the maintenance of an electronic database to which providers have access.

E. The Claim Review Process. (Page 13)

E.1. Types of Determinations a RAC may make. (Page 13) This section sets forth the following criteria for determining whether care provided by a Medicare provider was clinically reasonable and necessary. According to the draft Statement of Work, care must be:

- Furnished in accordance with accepted medical standards;
- Furnished in an appropriate setting;
- Ordered by qualified personnel;
- Meets, but does not exceed, the patient's medical need; and
- Be as beneficial as available and appropriate alternative medical settings.

However, these criteria cannot be comprehensively and accurately assessed by RAC clinician reviewers – the medical director, RNs and therapists – who lack relevant hands-on experience. It is likely that many RNs and therapists would face great difficulty conducting these assessments without having an experienced medical director who can oversee the review process and weigh in on whether the type, duration and frequency of care align with these criteria. And while RAC medical directors may possess clinical experience in one or more areas, it would be unlikely for the medical director to have hands-on knowledge of the wide array of medical specialties and sub-specialties represented in the Medicare claims being reviewed. In addition, we are very concerned that RAC medical directors, RNs and therapists will not have familiarity with the range and availability of local health settings providing relevant alternative care – and therefore, would be unable to assess this criterion.

Given these major concerns, it is highly unlikely that RAC clinicians will have the wherewithal to make sound and evidence-based medical necessity assessments. Therefore, we strongly urge CMS to remove the medical necessity reviews from the RAC Statement of Work.

If CMS persists in requiring RACs to conduct medical necessity reviews, then the criterion on “alternative medical settings” should be withdrawn since it cannot be accurately implemented. In addition, it is crucial that the Statement of Work be modified to require that RAC medical directors have hands-on experience and are well-versed in the medical literature and standards of care for the type of care being reviewed. The Statement of Work should add a criterion requiring that medical necessity determinations also be based on existing medical necessity requirements.

E.3. Medicare Policies and Articles. (Page 15) This provision requires RACs to issue determinations that are consistent with national and local Medicare coverage policy. It appears that RAC reviewers also would be taking into consideration the criteria noted in the preceding section, such as local medical practices and the medical literature.

The AHA supports the requirement that RACs must comply with all existing coverage policies and guidelines. And since the RAC will be reviewing claims filed over time during which a wide array of coverage policies have changed, we strongly endorse the provision prohibiting RACs from applying a local coverage determination (LCD) retroactively to claims processed prior to the effective date of the policy. This provision should be extended to all forms of coverage policy, rather than solely applying to LCDs. This is especially important given that some RACs involved in the demonstration phase inappropriately denied claims by applying policies that were created after the claims were initially filed.

We take strong issue with CMS’ position that the Statement of Work will ensure that RACs will possess the clinical capacity to compare complex medical records to a wide array of coverage policies that change from year to year. If CMS is to proceed with requiring RACs to conduct medical necessity reviews, it is necessary to articulate the distinct steps the agency will take to ensure that RACs are able to accomplish this multi-faceted task to ensure that individualized reviews are conducted accurately and reliably across all RACs. Observations of the demonstration RACs medical necessity reviews raise tremendous concerns about inconsistency between the RAC audit findings and actual Medicare coverage policy.

E.4. Internal Guidelines. (Page 16) We urge CMS to make all RAC internal guidelines available to hospitals and other providers.

E.8. Individual Claim Determinations. (Page 18) We have strong concerns that RACs will lack the clinical judgment and relevant clinical experience to assess the full continuum of individual claims. It is highly unlikely that all RAC medical directors and

other clinician reviewers will possess the medical capacity to accurately and thoroughly assess the broad array of medical literature and local standards of practice relevant to the clinical areas subject to review. As such, as already stated, we urge CMS to withdraw the requirement for individual claims review of medical necessity from the RAC Statement of Work.

E.9. Staff Performing Complex Coverage/Coding Reviews. (Page 18) The requirement that coverage and medical necessity determinations be conducted by RNs and therapists does not go far enough. These clinicians should be required to have direct experience with the type of clinical service being reviewed to determine that these individuals have an adequate professional framework to assess the criteria outlined in Section E.1., as discussed above.

In addition, CMS should require that coders involved in performing complex coverage or coding reviews be credentialed by a nationally recognized organization. And CMS should require that, upon request from a provider, the RAC must provide an opportunity for the physician at the hospital to discuss the case with the RAC medical director who approved the denial.

E.10. Time frame for Completing Complex Coverage/Coding Reviews. (Page 18) This requirement establishes that RACs shall conduct timely reviews and may request exceptions from the normal time frame under extenuating circumstances. The AHA believes that once the original or extended (if provided) time frame has passed, the RAC should not be permitted to send a recoupment letter to the provider on the claim.

Also, as we noted in our prior comments, consistent with the flexibility provided to RACs under extenuating circumstances, CMS also should require RACs to give providers an extended time frame for submitting documents if there are extenuating circumstances affecting the provider.

Finally, the Program Integrity Manual reference in this section is incorrect and should refer to PIM section 3.4.1. The section to which CMS refers is automated reviews and not complex reviews.

F. Activities Following Review.

F.1. Rationale for Determination. (Page 19) The Statement of Work requires a RAC to provide a description of the Medicare policy or rule that was violated and a statement on whether the violation resulted in an overpayment or did not affect payment. The AHA recommends that this section include language that requires RACs to document the rationale for each determination within the letters sent to providers. Such specific information is necessary in order for a provider to determine whether the finding is appropriate and, if it is, to learn from the experience.

2.a. Validating the Issue. (Page 20) We support encouraging RACs to meet with other Medicare contractors to discuss findings, as this may help these contractors identify areas for provider education. In addition, we recommend that CMS encourage the RACs to meet with provider associations within their region, including those representing hospitals, physicians, skilled nursing facilities, etc.

In addition, the validation process between the RAC and the FI that occurs prior to sending out a medical record requests/demand letters should be discussed in advance with state/hospital associations as a step supporting transparency. Forcing RACs to be pro-active on these issues will help reduce the burden on hospitals with issues that are not valid denials and later are dismissed.

Also, the validation contractor should not be an existing Medicare contractor, due to potential conflict of interest concerns listed above. Rather, we recommend that an appropriate qualified independent validation contractor be selected and that the Statement of Work for this contractor include validating the proposed type and appropriateness of reviews the RAC selected. Reports of the validation contractor should be made publicly available.

3. Communication with Providers about Non-MSP Cases. (Page 20) We request clarification on how RACs will report claims that are the subject of both a simple and a complex review if the complex review outcome is appealed by the provider.

3.b. Complex Review. (Page 20-21) We support this requirement for RACs to communicate the outcome of each medical necessity review involving a medical record, including cases where no improper payment was identified. Reporting information shall include the specific coverage/coding/payment policy or article that was violated. The most efficient method of communicating this type of information would be through a RAC/FI/provider electronic platform.

4.a. Full Denials. (Page 21) The Statement of Work provisions regarding full denial are inconsistent with the RAC demonstration experience in which providers are experiencing a full denial, when they should be receiving a partial denial. If a RAC determines that a less-intensive setting is appropriate, then the provider is eligible to keep the portion of the original payment that would cover the cost of care in the less-intensive setting. In contrast to this requirement, the RAC demonstration has generally not issued partial denials. For example, RAC demonstration reviews of inpatient rehabilitation claims often resulted in full denials following a RAC determination that the case was appropriate at a less-intensive level of care. These cases should be eligible for retroactive partial adjustments, and similar cases in the future should receive partial denials in lieu of full denials. CMS should ensure that full denials are not permitted if a different service might have been appropriate.

4.b. Partial Denials. (Page 21-22) This provision would allow RACs to identify a lower level of care that would have been reasonable and necessary for a patient in lieu of the

actual level of service submitted by the provider. RACs then are to reduce the Medicare payment to a lower amount commensurate with the lower level of service it selected as the appropriate level of treatment. The RAC is authorized to collect the difference between the original payment and the adjusted amount that “should have been paid.”

It is inappropriate for RACs to attempt to determine appropriate alternative care for any claim that is denied based on an inadequate level of medical necessity. Review of a medical chart does not provide an adequate basis for such a determination given the complexity of a referral process.

For partial denials, CMS should clarify that if a RAC determines that an inpatient service could have been provided as an outpatient service, the hospital may re-bill the claim as an outpatient service or at least as an inpatient Part B only claim. In these instances, overpayment should be calculated as the difference between the inpatient DRG amount and the alternate payment. (The contingency fee should be calculated on this amount, as well.)

4.c. Extrapolation. (Page 22) As we stated earlier, it does not appear that extrapolation is permitted for RACs since RAC reviews are not based on a random selection of claims. While there is a limited provision in the PIM that allows sampling, if CMS does not intend for RACs to utilize extrapolation then it should be stricken from the Statement of Work.

4.d. Recording the Improper Payment Amount in the RAC Data Warehouse. (Page 22) We recommend that the data in the RAC Data Warehouse be made available to providers to track the status of these requests and take backs.

I. RAC Medical Director. (Page 23) While we strongly support the requirement that RACs employ a physician medical director, the Statement of Work does not provide for meaningful involvement of the physician in medical record review or even oversight of such review. We believe that only one full-time equivalent physician per RAC will not provide adequate medical involvement or range of clinical expertise and experience. A major shortfall of the current RAC demonstration process is the lack of physician involvement in medical records review and determinations of medical necessity. The AHA recommends that CMS require that RAC contractors employ physician personnel in adequate numbers and areas of specialty to ensure appropriate chart review and compliance with Medicare regulations, or limit their review responsibility to non-medical necessity areas.

Relevant Work Experience. (Page 23) While we support the requirement that the RAC medical director be “actively involved in examining all evidence used in making individual claim determinations and acting as a resource to all reviewers...”, the benefit of this requirement will be limited largely to the clinical experience of the medical director. For the medical director to be able to provide relevant guidance to the RNs and therapists reviewing individual medical charts to assess medical necessity, the medical

director(s) or other physicians participating in the review team must have relevant work experience. The criteria put forth in the Statement of Work fail to require relevant clinical experience and simply require that *preference be given* to “physicians who have patient care experience.” This standard must be strengthened to ensure that the RAC review team can handle the multi-faceted criteria that must be assessed to determine whether a particular patient was medically appropriate for the care received. As such, the clinicians conducting reviews should be *required* to have relevant hands-on experience if CMS is to rely on their determinations to override the clinical expertise of the treating/referring physician.

On another note, we support the requirement that the medical director participate in presentations to providers and associations and encourage that such presentations include *proactive* outreach to affected stakeholders.

I. Assisting CMS in the development of the Medicare Improper Payment Prevention Plan. (Page 24) The Statement of Work includes several references to RAC input into CMS policy development: These statements requiring the RAC to “support CMS in developing an Improper Payment Protection Plan” and to “Recommend corrective actions, (LCD change system change, provider education)” represent a significant expansion of the role of the RAC into the development of policy from their initial responsibility of claims review and reimbursement recovery. We believe that this is an inappropriate role for RACs and is beyond the scope of the project originally mandated by Congress. Development and changes to Medicare payment policy is the responsibility of CMS, and must include the opportunity for provider and beneficiary input.

J. Communication with Other Medicare Contractors. (Page 24)

J.2. Referrals from CMS. (Page 24) It is not appropriate for CMS to permit contractors that are paid on a contingency fee basis to receive these kinds of tips. If CMS were aware of areas of overpayment or errors, it would be more efficient and less costly to the Medicare program for CMS to address such areas directly with providers and the current Medicare payment contractors including FIs, carriers and Medicare administrative contractors (MACs).

J.3. Referrals from RAC to CMS. The tracking system mentioned in this section is intended to track claims referred by a RAC to other CMS contractors for investigation. The provision notes CMS’ plan to develop a Web-based referral tracking system for this purpose. The elements of this system that show the status of claims that are under review and, as applicable, under appeal, should be shared with the public. Given the large number of CMS contractors engaged in claims review – FIs, RACs, MACs and QIOs – this would help reduce confusion among both contractors and providers.

Task 3. Non-MSP Underpayments. (Page 25)

Task 3. Non-MSP Underpayments – Provider Inquiries. (Page 26) Change the title of this section by adding the words “Related to Receipt of Non-Requested Case Files Submitted by Providers for Underpayment Case Review” after “Provider Inquiries” and add, “non-requested” before “case files” in both sentences. Otherwise this language seems too open-ended and might imply that the RAC never has to listen to the provider.

Task 3. Non-MSP Underpayments – Appeal of the Underpayment Determination. (Page 26-27) This section refers to a “RAC rebuttal process,” but this is not described anywhere in the Statement of Work. CMS should document the process that providers can follow and the time frame by which each step of the process must take place. The time period for rebuttal should be at least 20 days from the date of the RAC’s determination.

G. Recoupment During the Appeals Process. (Page 35) We strongly endorse the requirement that all RAC recovery and recoupment efforts be ceased once the RAC is notified of the appeal request. This would allow the due process measures to be carried out before a provider may be penalized. For those RAC denials that are overturned upon appeal, it would be unreasonable and excessive to prematurely recoup dollars, which would cause unjustified operational disruptions prior to the conclusion of the appeals process.

H. Customer Service – Paragraph 2. (Page 36) CMS must clearly state that, for overpayments, a provider can appeal all denials. We have learned that in the demonstration project states, providers are sometimes told that they can only appeal a claim that was denied for medical necessity.

Task 7C. Administrative and Miscellaneous Issues; Payment Methodology. (Page 40) We strongly support the provision to require that RACs repay to Medicare any contingency payments for claims that are appealed and adjudicated in the provider’s favor. This eliminates inappropriate incentives for RACs to conduct excessive claims denials in order to boost contingency payments from Medicare.