

HEALTH LAW ALERT

TO: Clients and Friends
FROM: Burr & Forman Health Care Practice Group
DATE: December 2009
RE: RAC Audits

There have been two recent developments with regard to the Medicare Recovery Audit Contractor ("RAC") program: (1) new documentation request limits for RAC DRG Validation Audits in 2010, and (2) new CMS approved RAC audit issues for Alabama. Below please find detailed information regarding these developments.

1. New Documentation Request Limits for RAC DRG Validation Audits in 2010.

The Centers for Medicare & Medicaid Services ("CMS") recently revised the documentation request limits for RAC DRG Validation Audits in 2010. While the number of record requests may vary depending on the average monthly Medicare claims submitted, these documentation limits establish a cap per campus (as opposed to per NPI) on the maximum number of medical records that may be requested by the RAC every 45-day period. Through March 2010, a maximum of 200 medical records per campus may be requested every 45-day period. Beginning in April 2010, providers who bill in excess of 100,000 claims to Medicare will have a maximum of 300 record requests per campus every 45-day period. Further, beginning in July 2010, the RAC may request permission to exceed these limits on a case by case basis.

Attached please find additional information regarding the new RAC documentation request limits.

2. New CMS-Approved RAC Audit Issues for Alabama.

Connolly Healthcare, the RAC for Region C,¹ recently posted new CMS-approved audit issues for Alabama. The new RAC audit issues include:

¹ Connolly is tasked with auditing Region C, which consists of the states of AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV and the territories of Puerto Rico and U.S. Virgin Islands.

CMS Approved Issue	Description	Provider Type Affected
Upper Limb and Toe Amputation for Circulatory System Disorders with MCC: MS-DRG 255*	Reviewers will validate for MS-DRG 255, previously DRG 114 principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Cirrhosis and Alcoholic Hepatitis with MCC: MS-DRG 432*	Reviewers will validate for MS-DRG 432, previously DRG 202, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Septicemia without Mechanical ventilation 96+ Hours without MCC: MS-DRG 872*	Reviewers will validate for MS-DRG 872, previously DRG 576, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Nonextensive O.R. Procedure, Unrelated to Principal Diagnosis without CC/MCC – MS-DRG 989*	Reviewers will validate for MS-DRG 989, previously DRG 477, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with MCC: MS-DRG 987*	Reviewers will validate for MS-DRG 987 previously DRG 477, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Other Respiratory System O.R. Procedures without CC/MCC: MS-DRG 168*	Reviewers will validate for MS-DRG 168, previously DRG 076/077, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Extensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC: MS-DRG 983*	Reviewers will validate for MS-DRG 983, previously DRG 468, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Other Respiratory System O.R. Procedures with CC: MS-DRG 167*	Reviewers will validate for MS-DRG 167, previously DRG 076, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital

CMS Approved Issue	Description	Provider Type Affected
Other Digestive System Diagnoses with CC: MS-DRG 394*	Reviewers will validate for MS-DRG 394, previously DRG 188, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Inflammatory Bowel Disease with CC: MS-DRG 386*	Reviewers will validate for MS-DRG 386, previously DRG 179, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Gastrointestinal Disorders and Peritoneal Infections with CC: MS-DRG 372*	Reviewers will validate for MS-DRG 372, previously DRG 572, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Other Respiratory System O.R. Procedures with MCC: MS-DRG 166*	Reviewers will validate for MS-DRG 166, previously DRG 076, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Small and Large Bowel Procedures without CC/MCC: MS-DRG 331*	Reviewers will validate for MS-DRG 331, previously DRG 570, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Small and Large Bowel Procedures with CC: MS-DRG 330*	Reviewers will validate for MS-DRG 330, previously DRG 569, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Small and Large Bowel Procedures with MCC: MS-DRG 329*	Reviewers will validate for MS-DRG 329, previously DRG 149, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Chest Procedures without CC/MCC: MS-DRG 165*	Reviewers will validate for MS-DRG 165, previously DRG 075, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital

CMS Approved Issue	Description	Provider Type Affected
Major Chest Procedures with MCC: MS-DRG 163*	Reviewers will validate for MS-DRG 163, previously DRG 075, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Major Chest procedures with CC: MS-DRG 164*	Reviewers will validate for MS-DRG 164, previously DRG 075, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Respiratory System Diagnosis with Ventilator Support 96+ Hours: MS-DRG 207*	Reviewers will validate for MS-DRG 207, previously DRG 565, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Septicemia without Mechanical Ventilation 96+ Hours with MCC: MS-DRG 871*	Reviewers will validate for MS-DRG 871, previously DRG 576, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC: MS-DRG 981*	Reviewers will validate for MS-DRG 981, previously DRG 468, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC: MS-DRG 982*	Reviewers will validate for MS-DRG 982, previously DRG 468, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Nonextensive O.R. Procedure Unrelated to Principal Diagnosis with CC – MS-DRG 988*	Reviewers will validate for MS-DRG 988, previously DRG 477, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital
Coagulation Disorders: MS-DRG 813*	Reviewers will validate for MS-DRG 813, previously DRG 397, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG**	Inpatient Hospital

CMS Approved Issue	Description	Provider Type Affected
Once in a lifetime procedures	By virtue of the description of the CPT code, these codes can be performed only once per patient lifetime. Claims with modifier-58 will be excluded from your audit with dates of services starting 1/1/09. Starting 1/1/09 this code was allowed to be billed more than once if the provider used the modifier	Outpatient Hospital and Physician
J2505: Injection, Pegfilgrastim, 6 mg	Claims for J2505 should be submitted so that the units billed represent the number of multiples of 6mg administered, not the total number of mgs	Outpatient Hospital and Physician

**Per Connolly, Medical Necessity is excluded from review at this time.*

***DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record.*

For additional information and guidance on these RAC audit issues, please refer to Connolly's website at: www.connollyhealthcare.com/RAC/.

In the event that you have any questions about RAC audits and/or your health care practice in general, please feel free to contact any of the following attorneys in our Health Care Practice Group.

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No representation is made about the quality of the legal services to be performed or the expertise of the lawyer performing such services.

THIS IS AN ADVERTISEMENT. FREE BACKGROUND INFORMATION AVAILABLE UPON REQUEST.

Attachment

Additional Documentation Limits for FY 2010 for DRG Validation as of December 1, 2009

In response to feedback from the RACs, providers/suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program in FY 2010. These limits will be set by each RAC (CMS) on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit (defined below) may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior calendar year Medicare claims volume.

1. Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located. Using TINs will reduce the total number of limits that would have been imposed per organization under the previous draft policy, which was based on National Provider Identifiers, while factoring in ZIP codes will promote equitability for regional or national organizations. For example:

- Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.
- Provider B has TIN 123456780 and is physically located in 12345 as well as 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

Please note that the definition of a campus for RAC documentation request limits differs significantly from the definition in 42 CFR 413.65(a)(2) used to determine eligibility for provider-based billing.

2. Limits will be set at 1% of all claims submitted for the previous calendar year (2008), divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services. Note: FY 2010 limits are based on submitted claims, irrespective of paid/denied status and/or individual lines, although interim/final bills and RAPs/final claims shall be considered as a unit. For example:

- Provider C billed 156,253 claims last year. The provider's additional documentation limit would be $(156253 * .01) / 8 = 195.31$, or 195 additional documentation requests per 45 days.
- Provider D billed 50,000 inpatient claims, 75,000 outpatient claims, 20,000 SNF covered stays, 20,000 home health episodes of care, 250,000 physician claims, 10,000 inpatient rehab claims and 1,000 hospice claims. The total number of claims for this provider would equal 426,000. The provider's additional documentation limit would

be $(426000 * .01) / 8 = 532.5$. The provider's additional documentation limit would be 532 additional documentation requests every 45 days, if there were no cap in place (see below).

While respecting a provider's overall limit, the RAC may exercise discretion in the exact composition of an additional documentation request. For example, the RAC may request inpatient records up to the full limit even though the provider's inpatient business may only be a small portion of their total claim volume.

3. Two caps will exist in FY 2010: Through March 2010, the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers. However, from April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per TIN, across all claims processing contractors) will have a cap of 300 additional documentation requests per campus unit, per 45 days.
4. In addition, in FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.

Questions concerning this update can be directed to RAC@cms.hhs.gov.