Indiana Hospital Association
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Medicare and Medicaid Recovery Auditor Newsletter

December 2014/January 2015

If there are any RAC concerns that need to be addressed with CGI, HMS, Truven Health Analytics, OMPP or CMS, please contact Dave Wiesman, IHA Vice President, at dwiesman@IHAconnect.org or 317-423-7741.

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CGI NEWS

Beginning January 1st, 2015 the Centers for Medicare and Medicaid Services has agreed to extend the recovery program for Region B and approved CGI to continue post payment automated reviews, DRG Complex reviews and Drug Unit Complex reviews. Additional review issues may be added at any time through the length of this extension, solely at the discretion of CMS. The current contract is scheduled to run through December 31st, 2015.

On January 9th, CGI sent ADR letters for DRG and Drug Unit reviews to OH, KY, IL, IN and MI Hospitals.

Hospitals are reminded to update their addressees on the CGI Web Portal.

CMS "Validation Contractor" is doing monthly reviews of CGS's findings. The contractor is conducting 100 reviews per month. The accuracy rate for December for CGI was 99%; for January is was 91%. CGI is reviewing the results.

CGI will continue monthly calls with the Region B Hospital Associations in order to report activity, accuracy rates and solicit any concerns from the provider community.

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CMS NEWS

On January 14th, CMS reported that due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract. Questions regarding the protest may be directed to the GAO. CMS will post updates on this protest as appropriate.

At the beginning of January, 2015, CMS announced changes to the RAC Program that the agency believes will reduce provider burden, enhance CMS's oversight and increase transparency in the program. Some of the changes are as follows:

- CMS will limit the RAC look-back period for patient status reviews to six months after the date of service if the hospital has submitted its claim within three months of the date of service. CMS believes this addresses concerns regarding its policy that limits hospitals' ability to rebill certain denied Medicare Part A claims under Part B to one year after the date of service.

- CMS will establish ADR limits based on a provider's compliance with Medicare rules. Providers with low denial rates will have lower ADR Limits while provider with high denial rates will have higher ADR limits. The ADR limits will be adjusted as a provider's denial rate decreases, ensuring that provider that complies with Medicare rules has less recovery audit reviews.

- CMS ADR limits will be diversified across all claim types of a facility (inpatient, outpatient, rehab, etc.). This ensures that a provider with multiple claims types is not disproportionately impacted by recovery audit reviews in one claim type.

- RAs will have 30 days to complete complex reviews and notify providers of their findings rather than 60 days.

- RAs must wait 30 days to allow for a discussion request before sending the claim to the MAC for adjustment.

- RAs must confirm receipt of a provider's discussion request within three business days.

- RAs will be required to maintain an over turn rate of less than 10% at the first level of appeal.

- RAs will be required to maintain an accuracy rate of at least 95%. Failure to maintain this rate will result in a progressive reduction in ADR limits.

CMS says the changes will be effective with each new RAC contract.

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