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# RAC Auditors for Regions B, C and D Publish Lists of CMS Approved Issues for RAC Audits

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As part of the expansion of CMS' Recovery Audit Contractor ("RAC") initiative from a demonstration project to a permanent program, CMS requires that each of its four RAC contractors have issues subject to RAC review pre-approved by CMS and posted to the RAC's website. By way of background, RAC Audits consist of two types of reviews: (1) automated reviews; and (2) complex reviews. For automated reviews, RACs use data mining techniques to identify obvious payment errors, such as where a provider submitted a duplicate claim for the same service. For complex reviews, the RAC determines that a payment error likely occurred using data analysis. RACs are unable to review claims paid prior to October 1, 2007.[1]

Approved issues were recently released for Region B for Indiana, Michigan and Minnesota providers; for Region C hospital and physician providers in Alabama, Georgia, South Carolina and Florida; for Region C Durable Medical Equipment ("DME") suppliers in all Region C states; and for Region D for providers in all Region D states.[2] As required by CMS, these initial reviews consist only of "automated reviews," which limits the RAC to identifying obvious payment errors, but does not include any medical record review.[3] The initial lists of issues primarily focus on outpatient hospital services, physician services and DME.

## Issues Subject to Review

CMS has approved for RAC review the following issues for outpatient hospital and physician services:

| Issue | Region B for IN, MI & MN | Region C for AL, FL, GA & SC | Region D (all) |
|---|---|---|---|
| **Blood Transfusions**. CMS guidelines provide that blood transfusions administered in the hospital outpatient or physician office setting must be billed with a maximum of one (1) unit per patient per date of service. | X | X | X |
| **IV Hydration.** CMS guidelines provide that intravenous hydration therapy administered in the hospital outpatient or physician office setting must be billed with a maximum of one (1) unit per patient per date of service (excluding claims with modifier 59). | X | X | X |
| **Bronchoscopy Services.** CPT codes 31625, 31626 and 31629 should be billed with a maximum number of units of one per patient per date of service (excluding claims with modifier 59). | X | X (only AL, GA & SC) | X |
| **Untimed Codes.** For CPT codes used in the outpatient or physician office setting (excluding claims with modifiers KX and 59) where the procedure is not defined by a specific timeframe (untimed codes), CMS guidelines require that the provider enter a one (1) in the units billed per date of service. | | X | X |
| **Once in Lifetime Procedures.** For those procedures that could only be performed once in a patient's lifetime, the RAC may identify the additional procedures billed for the same patient for repayment. For example, where a provider previously billed for a total shoulder replacement, a second bill submitted for a total shoulder replacement (as opposed to a revision surgery) may be identified for repayment. | | X (only FL, GA & SC) | X |
| **Pediatric Codes Exceeding Age Parameters.** Newborn/pediatric CPT codes billed for patients that exceed the age limit defined by the CPT code may be identified for repayment. | | X (only AL, FL & SC) | X |

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|---|---|---|---|
| **J2505: Pegfilgrastim (Neulasta) Injection, 6 mg.** Because by definition the HCPC Code J2505 represents 6 milligrams per unit, the J2505 code should be billed as one unit per 6 mg of the drug administered, not one unit per milligram administered. Where an injection is billed as 6 units rather than 1 unit, the additional units may be identified for repayment. | | X (only FL, GA & SC) | X |
| **Clinical Social Work.** Clinical Social Worker services rendered during an inpatient hospital stay are not separately payable by Medicare Part B; they are included in the facility's Prospective Payment System. Where Clinical Social Worker services were separately billed, they may be identified for repayment. | | X (only FL) | |

For DME suppliers in all Region C states, CMS has approved for RAC review the following two issues:

- **Wheelchair Bundling.** Coding guidelines provide that where wheelchair options/accessories are included in the "global" payment for certain codes, the options/accessories are not separately payable.

- **Urological Bundling.** Urological supplies consist of catheters and urinary collection devices. Coding guidelines provide that certain components of the catheter kits are not separately billable and are included in the "global" payment for the kit.

The applicable manual provisions and publications detailing the billing and coding requirements for each approved audit issue are provided on the RAC websites.

## Next Steps for Providers

Although the approved issues listed above are limited to Regions B, C and D and the specific states indicated, we expect that Region A will likely seek similar approval for automated reviews. Providers who bill for any of the services on the approved list should assess their current billing practices to confirm that these services are being billed correctly. To the extent any issues are identified, providers will want to put processes in place to assure that these services are billed pursuant to CMS guidelines.

Where, as part of its automated review, the RAC identifies a potential overpayment, a demand letter detailing the overpayment amount and alleged billing rule violated will be directed to the provider. While overpayment determinations may be appealed through the CMS appeals process, issues for automated review are typically black and white issues, such as billing twice for the same procedure on the same day, and are unlikely to be successful on appeal.

While no specific issues have yet been approved by CMS for complex reviews, CMS has authorized complex reviews for coding and Diagnostic Related Group ("DRG") assignments in many states beginning in August 2009, with the remaining states subject to coding and DRG review by November 2009. In addition, CMS has approved medical necessity reviews for all states beginning in 2010. Fortunately, providers enjoyed a high success rate when appealing complex reviews during the Demonstration Phase, with some contractors having more than 50 percent (50%) of their reviews overturned. Thus, providers may want to consider devoting more of their limited resources to appealing complex reviews.

We will continue to monitor the implementation of the RAC program and issue additional client alerts as new issues for RAC review are approved by CMS.

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[1] Additionally, going forward, RACs are not authorized to review claims more than three (3) years after the claim was paid.

[2] For CMS' RAC initiative, CMS has divided the country into four (4) regions: A, B, C and D. RAC Region A includes Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont. RAC Region B includes Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin. RAC Region C includes Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia and the territories of Puerto Rico and U.S. Virgin Islands. Finally, RAC Region D includes Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming. The RAC for Region A is Diversified Collection Services (www.dcsrac.com); the RAC for Region B is CGI (http://racb.cgi.com); the RAC for Region C is Connolly Consulting (www.connollyhealthcare.com/RAC); and the RAC for Region D is HealthDataInsights (http://racinfo.healthdatainsights.com).

[3] In contrast to automated reviews, for "complex reviews," RACs request medical records from the provider to conduct a more in-depth review and to make a determination as to whether an overpayment or underpayment occurred.

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**EDITOR**