Eli's Hospice Insider

Medical Review: Don't Be Surprised If RAC Review Is Around The Corner

Monthly billing make hospice claims a tempting RAC target.

Recovery Audit Contractor **Performant** has yet to name a specific audit topic related to hospice, but that doesn't mean you shouldn't worry about RAC review.

Why? Experts predict the RAC that has Medicare's home health, hospice and DME contract will announce hospice audit topics, particularly given the increased worry about fraud and abuse voiced by the **HHS Office of Inspector General** (see story, p. 31) and other government agencies. The fact that Performant recently named its first home health audit topic, on "Documentation and Medical Necessity," could indicate a hospice topic isn't far behind.

In the past, RACs haven't given attention to hospices because the amounts recovered per claim paled in comparison to providers like hospitals, and the RACs were paid on contingency. That's likely why the **Centers for Medicare & Medicaid Services** eventually decided to award one national RAC contract for home health, hospice and durable medical equipment.

RAC audits aren't just a problem for providers with high denial rates, notes consultant **Cindy Krafft** with **Kornetti & Krafft Healthcare Solutions**. Gathering all requested materials and submitting them within the RAC's 45-day timeline will translate into serious "resource consumption," Krafft says.

When you add denial recoveries on top of the cost of responding to ADRs appropriately, "financial implications could be high," Krafft warns.

Extrapolation Could Be Waiting In The Wings

Watch out: An even deadlier reimbursement blow may be in the offing as well. Performant assures providers in a Frequently Asked Question set on its website that "currently Performant is not using extrapolation." However, the RAC adds that "we have been approved to perform this method of analytics." Performant does promise it will furnish "appropriate communication" on its website "when we plan to perform this process."

But in its Region 5 Statement of Work, CMS goes into more detail that indicates it may consider extrapolation a good fit for home care claims, at least eventually. "The Recovery Auditor is encouraged to use extrapolation for some claim types when all requirements are met," the SOW reads. "Extrapolation may be cost effective for low-dollar claims that require complex review and have a history of having a high error rate."

However, Performant will have to secure CMS approval for extrapolation on an issue-by-issue basis, the SOW indicates.

Along with RAC reviews, expect to see appeals of RAC determinations pile up, offers finance expert **Tom Boyd** with **Simione Healthcare Consultants** in Rohnert Park, California.

However, CMS does note in its Statement of Work that is expects a 95 percent "accuracy rate" in RAC reviews, and that it expects fewer than 10 percent of determinations to be overturned at appeal.

Reminder: RACs are paid solely on a contingency fee basis, earning a percentage of the recoveries they produce from their reviews. They do get paid for underpayments they find as well as overpayments, however, notes **National Association for Home Care & Hospice** President **William Dombi**.

For Performant's work as the home health, hospice, and DME RAC, it receives an 8 percent contingency fee, a CMS spokesperson tells **Eli**. That rate was disclosed when CMS announced the contract for Region 5, which covers the entire

nation, in 2016.

But Performant can earn an even higher fee than 8 percent, the CMS source notes.

How? The Statement of Work for Region 5 specifies that for every point a RAC comes in under the 10 percent appeal overturn cap, it will earn a 0.1 percent increase to its contingency fee. Thus, Performant can earn an 8.1 percent fee if its overturn rate is 9 percent, an 8.2 percent fee if its overturn rate is 8 percent, and so on. Theoretically, if the RAC had a 0 percent overturn rate, it would receive a 9 percent fee. Of course, a 0 percent rate is pretty much impossible.

Presumably to counteract the bounty hunter incentives to the contingency fee contract, CMS does impose some adverse actions if Performant exceeds the 10 percent overturn rate. Those consequences range from reducing the number of Additional Development Requests the RAC may issue to terminating its contract.

Why Hospice Claims May Soon Be In The RAC Crosshairs

The contingency fee payment structure incentivizes the RAC to seek out the highest-dollar claims with problems for review, notes consultant **Pam Warmack** with **Clinic Connections** in Ruston, Louisiana. Denials of those high-payment-level claims will result in the highest payments to Performant.

The contingency fee structure makes hospice claims a tempting target, Boyd suggests. That's due to the dollar amount of the average hospice claim versus home health agency claim, Boyd says.

The good news is that the 10 percent cap on successful appeals should help temper Performant's zeal for denying claims. "Limits on incorrect decisions [are] a good thing for agencies," says **Judy Adams** with **Adams Home Care Consulting** in Durham, North Carolina. "It should mean a decrease in nit-picking denials."

Warmack agrees, saying "it is encouraging to know that they are held to a performance indicator."

Appeal RAC Denials

If you receive a denial from the Recovery Audit Contractor when it reviews your claim, all is not lost.

"Appeal every denial," Boyd emphasizes.

First step: Before you file a formal appeal, you can request a "discussion period" from the RAC.

"You are encouraged to file a Discussion prior to an Appeal," Performant said in a webinar for providers given last year. "This gives the RAC the opportunity to evaluate the original determination."

Using the Discussion option "lessens the administrative burden for both you and your Medicare Administrative Contractor," Performant said.

Providers have 30 calendar days from the RAC determination to submit a request for a Discussion Period, the **National Association for Home Care & Hospice** says in its provider newsletter. The 30-day period begins from the date of the Review Results letter. The RAC has 30 days from receipt of the Discussion Period request to respond to the provider.

If you do decide to move forward with a formal appeal, it goes through the usual process via your Medicare Administrative Contractor, Performant noted.

Note: See the Region 5 SOW at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/New_RAC-SOW-Region-5-clean.pdf.