RAC Prepayment Review and Hospital Rebilling Demonstration Programs

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I. Background

On November 15, 2011, the Centers for Medicare and Medicaid Services ("CMS") announced two demonstration programs that directly impact inpatient short stay claims for Michigan hospitals. The first demonstration program is voluntary and is called the Part A to Part B Rebilling Demonstration Program. The second program, the Recovery Auditor Pre-Payment Review Demonstration Program, is mandatory for providers in 11 states including Michigan. Hospitals included in the new demonstration programs—every hospital in Michigan may be included, depending on the services it bills, in at least the RAC Prepayment Review demonstration--must be aware of the most current updates to these demonstration programs, as well as recent audit developments.

II. Recovery Audit Pre-Payment Review Demonstration Program

The Recovery Audit Pre-Payment Review Demonstration Program, unlike the AB Rebilling Demonstration Program, is mandatory and will have a dramatic effect on providers in Michigan because it allows Recovery Audit Contractors (RACs) to conduct pre-payment reviews of providers' Medicare claims. Prior to the announcement of this demonstration program and in states outside of the demonstration program, RACs could only conduct post-payment reviews of providers' Medicare claims. While on December 30, 2011 CMS announced the implementation of the RAC Demonstration was delayed until further notice, CMS recently announced that the demonstration is now set to begin no sooner than June 1, 2012. With the scheduled implementation date approaching, it is important for providers to understand the basics of the program. As, providers that have been subject to pre-payment review in the past can attest, any time Medicare withholds payment for claims in the normal course of business, major cash-flow problems can result. While hospitals are the initial targets and may be able to withstand a small volume of claims under pre-payment audits, the program will expand to a significant amount of DRGs, and will likely include physician claims in the future.

The Pre-Payment Demonstration will allow RACs to review claims before they are paid to ensure the provider complied with all Medicare payment rules. CMS selected 11 states for the demonstration program, including Michigan. At the beginning of the demonstration program, RACs will only review inpatient short-stay claims for MS-DRG 312 Syncope & Collapse. As the program progresses, CMS has indicated that it will initiate pre-payment review of seven more DRGs. The additional reviews suggest that CMS will add more claims in the future, including possibly physician claims. It is also important to note that the demonstration program is in addition to, and does not replace the current post-payment RAC Program, which has continued to gain steam.

There are serious implications for providers subject to the pre-payment demonstration program. Pre-payment review is an aggressive, and sometimes draconian, method for RACs to audit providers before Medicare pays a claim. Because of this, pre-payment review may significantly impact cash flow and there are no substantive criteria or formal procedures in place for removal from review. Unfortunately for hospitals in Michigan hospitals are advised to prepare for the impact of pre-payment review and the inevitable cash flow

issues that follow. Pre-payment review may force hospitals to absorb the costs of expensive procedures and admissions for long periods of time while a RAC reviews the claim, and in the case of a claim denial, the time for appeal. In fact, if a hospital appeals a denied claim within 30 days at each level of appeal, it could take a year before the claim reaches the ALJ level of appeal.

III. AB Rebilling Demonstration Program

The Part A to Part B Rebilling Demonstration Program is yet another attempt by CMS to achieve its goal of reducing improper Medicare payments. The Rebilling Program will involve up to 380 hospitals determined through a first-come first-served application process. The 380 participants will be split into groups of 80 large hospitals (300+ beds), 120 moderate hospitals (100-299 beds) and 180 small hospitals (99 or less beds). The program is scheduled to run for three years, from January 1, 2012 to December 31, 2014. Enrollment for the program opened on December 12, 2011 at 2pm ET.

The Rebilling Program allows hospitals to rebill certain Part A claims for Part B reimbursement. Specifically, the program allows hospitals to rebill as Part B outpatient service, Part A short-stay inpatient claims denied beginning January 1, 2012 by a Medicare Administrative Contractor, Zone Program Integrity Contractor, Recovery Auditor, or a Comprehensive Error Rate Testing (CERT) because the services were provided in the incorrect setting. In addition, a provider may resubmit any short-stay inpatient claims the provider self-identifies as rendered in the incorrect setting, after the services were provided and billed, but before the services are denied.

If a hospital rebills a Part A claim for Part B reimbursement—either because the claim was denied by a contractor or the hospital finds a mistake, it will receive 90 percent of the total Part B payment, not including observation services, and will be required to refund the difference of the beneficiary's co-pay and deductible due under Part A and Part B. CMS's rationale for only paying 90% of the normal Part B fee is to address concerns that full payment would encourage hospitals to "game" the system and would incentivize inaccurate billing.

The most problematic aspect of the Rebilling Program is that in electing to participate, a hospital waives its right to appeal if a claim was denied for service in an inappropriate setting. The Rebilling Demonstration requires hospitals to make a hard decision between two imperfect choices: either give up appeal rights and accept 90% of Part B reimbursement, or retain the right to appeal, but not the right to rebill the Part A claim under Part B if the appeal is unsuccessful.

IV. Conclusion

The two proposed Medicare demonstration programs present major challenges for hospital providers in Michigan. Currently, there is no effective mechanism for providers that are not a part of the AB Rebilling Demonstration program to receive Part B payment for services determined to be incorrectly billed under Part A. As a result, it is essential that hospitals continue to appeal Part A claims denied for medical necessity due to incorrect place of service and in the alternative seek Part B reimbursement through the Medicare appeals process. The Pre-Payment Demonstration will likely cause hospitals, and perhaps physicians, cash flow and business disruption issues as claims are reviewed and denials are appealed before payment is made.

The demonstration programs announced on November 15, 2011 reflect the current state of the Medicare program and the federal government's efforts to curb improper payments to providers. They also reflect, the need for hospitals to prepare for these new initiatives in the Medicare program.