

QIOS, RACS AND SITE OF SERVICE FAQ

GuidePoint

Simplifying Reimbursement

Cardiac Rhythm Management
and Electrophysiology

Updated March 2010

An Overview for Hospitals and Physicians Performing Coronary Stent and Defibrillator (ICD) Procedures

Overview

With the rapid expansion of Medicare's efforts to contain improper payments for health care services, many hospitals and physicians are experiencing increased scrutiny of admission, coding, and billing practices. This document describes two Medicare audit programs that are having a growing impact on Cardiac Rhythm Management (CRM) and Interventional Cardiology (IC) implant procedures.

The Medicare program utilizes Quality Improvement Organizations (QIOs) and Recovery Audit Contractors (RACs) to monitor hospital claims to avoid paying for inappropriate hospital services. The following is presented to answer questions regarding the guidelines for determining the most appropriate site of service and the role of QIOs and RACs in auditing those guidelines.

The following frequently asked questions cover guidelines for site of service, QIOs and RACs along with some additional resources for more in-depth information on these organizations.

Site of Service Guidelines

1. What are the site of service guidelines for implantation of cardiac defibrillators and Percutaneous Transluminal Coronary Angioplasty (PTCA) with stent placement?

According to practice guidelines (such as InterQual or Milliman), non-urgent PTCA with stent placement and transvenously placed ICDs can be safely performed in the hospital outpatient department. If there is a medical justification for the procedure to be performed in the inpatient setting, the physician must issue clear admission orders ("admit to hospital" vs "place in observation") and the medical justification **must** be clearly and accurately documented in the patient's medical record.

Medical necessity is also guided by the general rules for inpatient admissions which are:

- Can the procedure be safely provided in an alternate site of service?
- Document patient co morbidities and underlying need for admission.
- Clearly note "Admit to Inpatient Status" or "Place in Observation" – avoid vague terms such as "Admit".
- Communicate: Notify Director of Admitting, Utilization Review Director and/or Medicare Compliance Officer.

In addition, a patient is typically only admitted on an inpatient basis when he/she has an acute condition requiring treatment only in a hospital setting and, based on the physician's assessment, is unlikely to be ready for discharge within 24 hours. If the non-emergent patient has co-morbidities that require intense monitoring or hospitalization, the information must be clearly noted in the patient's chart to support the medical necessity of an inpatient admission.¹

¹ See QIO Manual, Chapter 4, Case Review, <http://www.cms.hhs.gov/manuals/downloads/qio110c04.pdf> for discussion of inpatient criteria.

2. What guidance is available from Specialty Societies?

The Heart Rhythm Society has issued a position document on Hospitalization Criteria for Pacemaker and ICD Placement and EP/Ablations. This document lists criteria that may be helpful to determine the appropriate setting for these procedures. It must be recognized and acknowledged that this determination is a clinical decision best made by the patient's attending physician after a careful consideration of multiple clinical factors including, but not limited to, the specific procedure planned, the urgency of the procedure, the hemodynamic stability of the patient, patient co-morbidities and the likelihood and consequences of complications arising from the procedure.

These criteria are available by clicking on the following link: [HRS position statement](#)

It should be noted that the Society for Coronary Angiography and Interventions (SCAI) and the American College of Cardiology (ACC) are in the process of developing additional specialty-society-driven guidance on coronary stenting hospital admissions and is anticipated to be available at www.scai.org in May of 2009.

3. What should a physician do if he/she is unsure about the need for an admission?

Generally, the physician could consider placing the patient in outpatient observation, as outpatient observation can be progressed to inpatient if the patient's condition warrants additional care and such need is clearly and accurately documented.²

QIOs (Quality Improvement Organizations)

1. What are the QIOs?

QIOs (formerly known as Peer Review Organizations) are Medicare contractors that work with providers and Medicare Part A Fiscal Intermediaries, Part B Carriers or Medicare Administrative Contractors [MACs] to ensure quality care with fiscal oversight. Each state has a QIO that focuses on initiatives for that state.

2. What is the QIOs job?

CMS has identified the following requirements for the QIO Program:³

1. Improve quality of care for beneficiaries
2. Ensure payment only for services and goods that are reasonable and medically necessary and are provided in the most appropriate setting
3. Protect beneficiaries by addressing individual complaints, notices, and appeals

3. How does a QIO determine which claims to deny?

QIOs may review whether the services and goods that are provided to Medicare beneficiaries are reasonable and medically necessary.² For ICDs or PTCA with stent placement, some QIOs review the appropriateness of one day stays through medical record review. Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. *Note: QIOs will automatically review hospital readmissions within 30 days.*⁴

4. What have the QIOs found?

QIOs have identified the following with respect to Coronary Stent and ICD procedures:

1. Outpatient observation being used when the patient should have been admitted
2. Patient being admitted when he/she should have been cared for in outpatient observation
3. Physician orders not accurately reflecting the level of care required and/or rendered
- 4.

5. What happens if my claims are denied by the QIO?

The QIO will provide an opportunity to present additional information. Please check with your state QIO for information on the appeal process. Generally, providers should carefully review the patient's medical record to identify all comorbidities and check them against the hospital bill. Additionally, the hospital's Medicare Compliance Officer should be notified of the denial or reclassification.

² See QIO Manual, Chapter 4, Case Review, <http://www.cms.hhs.gov/manuals/downloads/qio110c04.pdf> for discussion of outpatient observation.

³ CMS Quality Improvement Organizations, Overview; http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp#TopOfPage; accessed June 12, 2008.

⁴ CMS Quality Improvement Organizations, Statement of Work (SOW); <http://www.cms.hhs.gov/QualityImprovementOrgs/downloads/8thSOW.pdf>.

6. What can I do to avoid denials or reclassifications?

According to InterQual & Milliman criteria, ICD, and PTCA with stent procedures can be safely performed in the hospital outpatient department. If the physician believes it is unsafe to discharge the patient, admission orders can be written as "place in observation" or "admit to inpatient hospital" if the physician determines admission becomes medically necessary.⁵

RACs (Recovery Audit Contractors)

1. What are the RACs?

Beginning in March 2005, CMS conducted a 3-year demonstration program establishing Recovery Audit Contractors in the states of California, Florida, and New York to detect and correct improper payments. It should be noted that recovery audit function is not a new process, however with the establishment of the RACs, CMS has now hired outside organizations that operate solely on a contingency fee that is based on a percentage of improper payments identified and collected.

Congress has since required CMS to make the RAC program permanent and nationwide by no later than January 1, 2010. The agency has already expanded RAC review to Massachusetts, South Carolina, and Arizona, with plans to expand RAC review to several more states in 2008 and 2009, and all states by 2010. For more details on when RACs will be expanded to your state, see [RAC Expansion Schedule](#).

CMS announced a revised timeline for implementation of the permanent Recovery Audit Contractor program during a meeting for hospital executives held in Washington, DC in September, 2008. While implementation has been delayed, providers should still begin their preparation for the permanent program. HRS and SCAI are working with CMS and the American Hospital Association to ensure appropriate guidance is followed for identifying when inpatient care is necessary. CMS has stated that before the contingency RAC program is initiated in any state, one or more public meetings will be held to give providers visibility to the program, its areas of focus, and procedures.

2. How do the RACs determine improper payments?

During the demonstration project, RACs used automated software programs to review the last four years of provider claims to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, and medical necessity and coding. Over the three years of the demonstration program, RACs collected \$980 million, 84% of that total was identified as inpatient overpayments.⁶ RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect.

The following are the rules that the RACS must follow in the expansion program:⁷

RACs may attempt to identify improper payments resulting from:

- a. Incorrect payment amounts
- b. Non-covered services (including services that are not reasonable and necessary)
- c. Incorrectly coded services
- d. Duplicate services

RACs may not attempt to identify improper payments arising from:

- a. Services provided under a program other than Medicare fee-for-service
- b. The cost report settlement process
- c. Claims more than 3 years past the initial determination date ("look back period")⁸, however RACS can only go back to claims paid from 10/07
- d. Claims where the provider is without fault
- e. The random selection of claims

⁵ QIO Manual, Chapter 4, Case Review, <http://www.cms.hhs.gov/manuals/downloads/qio110c04.pdf>.

⁶ CMS presentation by Timothy Hill, May 13, 2008, source RAC Data Warehouse.

⁷ Medicare Update, January 28, 2008: Medicare Compliance, Reimbursement and Enforcement Resource, [Medicare Update: Recovery Audit Contractors: Don't Be Left in the Dark](#).

⁸ The look back period starts at the initial determination date and ends when a RAC issues a medical record request (complex reviews) or the overpayment notification letter (automated reviews). The initial determination date will be the claim paid date. RACs will be allowed to review claims during the current fiscal year.

- f. Claims with special processing numbers (e.g., claims in Medicare demonstrations)
- g. Prepayment review

RACs are not allowed to review a claim that has previously been reviewed by another entity nor a claim that is currently under review by another entity. Before beginning a claim review the RAC shall utilize the RAC Data Warehouse to determine if an exclusion exists for that claim. CMS created the RAC Data Warehouse to track information about claims reviewed by the RACs. Other Medicare contractors use this Data Warehouse to designate which claims had been previously reviewed and are therefore excluded from review by the RACs. If an exclusion exists for that claim, the RAC is not permitted to review that claim. If the exclusion is entered after the RAC begins its review, the RAC and CMS will be notified so that the RAC can cease all activity. This does not prohibit the RACs from reviewing one day stays in states where QIOs have initiated one day stay projects. The RACs, however, may not review a specific claim that is being or has been reviewed by the QIO.⁹

3. What is the difference between an automated review and a complex medical review?

RACs perform two types of review, an **automated** review and a **complex** medical review. RACs may use their own proprietary software and systems to perform an **automated** review (where no medical record is involved in the review) only in situations where there is certainty that the claim contains an overpayment.

In situations where there is a chance that the claim is payable (e.g., one day stays), the RACs may utilize **complex** medical review.¹⁰ When making a claim determination in the absence of a written Medicare policy, article or coding, RACs will be required to utilize appropriate medical literature and apply appropriate clinical judgment. CMS will also require that a RACs medical director be actively involved in examining all evidence used to make individual claim determinations. RACs may also request copies of medical records for complex reviews and RACs will be required to ensure that coverage/medical necessity determinations are made by RNs or therapists and coding determinations are made by certified coders.

4. What have been some of the experiences hospitals have had with RACs so far?¹¹

During the demonstration project RACs collected overpayment for the following issues:

1. Medical Necessity	40%
2. Incorrect Coding	35%
3. Insufficient Documentation	8%
4. Other	17%

5. What are some of the basic steps providers can take to prepare for the RAC program?

There are a number of activities that providers can undertake to prepare for the implementation of the nationwide RAC program, including:¹²

- Examine the RAC demonstration project and CMS documentation on the RAC program to identify possible target areas
- Continue to educate organizational leadership, compliance committee and functions, and possible targeted services lines about the RAC program as well as about good documentation, coding, and billing accuracy
- Proactively audit or review perceived vulnerabilities and take corrective actions where appropriate
- Develop a plan and internal processes to respond to RAC medical record requests, reviews, and determinations
- Learn how to navigate the Medicare appeals process

⁹ Draft Statement of Work for the Recovery Audit Contractor Program, <https://www.fbo.gov/utills/view?id=b444a5639284508631927167ca86356e>.

¹⁰ Medicare Update, January 28, 2008, [Medicare Update: Recovery Audit Contractors: Don't Be Left in the Dark](#).

¹¹ http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

¹² Medicare Update, January 28, 2008, [Medicare Update: Recovery Audit Contractors: Don't Be Left in the Dark](#).

6. What can I do about cases that the RAC deems as not medically necessary?

Once the RAC has completed a “complex review”, they have 60 days to review the information to determine whether an overpayment occurred due to inappropriate admission. Providers have the option to appeal a RAC determination.¹³

7. How does the appeal process work?

Regardless of whether the overpayment resulted from an automated review or a complex review, a provider still has the same right to appeal the RACs final determination that it would have for any other Medicare coverage determination. Providers should review CMS instructions, guidance, and any appeals-related correspondence to determine whether the appeals process will have any additional deviations under the RAC program.¹⁴ The physician or hospital is required to reimburse Medicare, even if they plan to appeal the decision. A RAC initial determination is not appealed to the RAC – rather it is appealed by the provider to the Medicare carrier or intermediary.

8. What has happened with appeals?

Per the Medicare Recovery Audit Contractor (RAC) Program: An evaluation of the 3-year demonstration program (June 2008)¹⁵

- a. 14.0% of determinations were appealed
- b. 4.6% of appeals were overturned

Resources

CMS Links

General information on the RAC program

<http://www.cms.hhs.gov/RAC/>

RAC expansion schedule

<http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

RAC FAQ's

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=toeZq04j&p_lva=&p_li=&p_new_search=&p_accessibility=0&p_srch=&p_sort_by=&p_gridsort=2%3A1&p_row_cnt=18&p_prods=&p_cats=&p_pv=4.497&p_cv=&p_search_type=answers.search_nl&p_nav=&p_page=1

Overview of QIOs

<http://www.cms.hhs.gov/QualityImprovementOrgs/>

QIO Scope of Work

http://www.cms.hhs.gov/QualityImprovementOrgs/04_9thsow.asp#TopOfPage

QIO Listing by state

<http://www.qualitynet.org/dcs/ContentServer?pagename=Medgic/MQPage/Homepage>

HRS links

HRS Website information on RACs

http://www.hrsonline.org/Policy/CodingReimbursement/resources/rac_member_advisory.cfm

Medicare Appeals Process

<http://www.hrsonline.org/Policy/CodingReimbursement/resources/upload/RACMedicareAppealsProcess.pdf>

HRS Position paper on Hospitalization Criteria for Pacemaker and ICD Placement and EP/Ablations

<http://www.hrsonline.org/Policy/CodingReimbursement/resources/upload/RAC-Guidelines-stationary.pdf>

¹³ Medicare Appeals Process, <http://www.hrsonline.org/Policy/CodingReimbursement/resources/upload/RACMedicareAppealsProcess.pdf>.

¹⁴ Medicare Update, January 28, 2008, [Medicare Update: Recovery Audit Contractors: Don't Be Left in the Dark.](#)

¹⁵ http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

Other links

HFMA Web Cast

<http://www.hfma.org/events/webcasts/rac0708.htm>

Medicare Update Newsletter

[Medicare Update: Recovery Audit Contractors: Don't Be Left in the Dark](#)

HFMA Forum discussion on RAC

http://www.hfma.org/forums/cfo/resources/CFO_RAC_Audits_Region11.htm

Decision Health audio conference - Strategies to deal with new Recovery Audit Contractors

<http://www.decisionhealth.com/conferences/A1452/register.html>

Illinois Health Information Management Association – RAC presentation

<http://www.ilhima.org/download/2008AM/handouts/RACApril2008IL.pdf>

Society for Coronary Angiography and Interventions (SCAI)

<http://www.scai.org>

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