



1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

January 7, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6034-P
PO Box 8016
Baltimore, Maryland 21244-8016

Re: File Code CMS-6034-P

Medicaid Program; Recovery Audit Contractors (75 *Federal Register* 69037)

Dear Dr. Berwick:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed regulation to provide guidance to States related to Federal/State funding of State start-up, operation and maintenance costs of Medicaid Recovery Audit Contractors (RACs), as published in the November 10, 2010 *Federal Register*. Our comments focus on those areas of particular interest to our member professionals.

AHIMA is a not-for-profit professional association representing more than 60,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the Health and Human Services Department related to the use of secondary data for a variety of purposes including quality monitoring, reimbursement, public health, patient safety, biosurveillance, and research. HIM professionals are also engaged in clinical record or billing audits which continues to challenge them as health information is stored electronically

Our detailed comments and rationale for the revised requirements are provided below.

§ 455.506 Activities to be conducted by Medicaid RACs.

Comment: We understand from the proposed regulation that States will have the ability to contract with 1 or more Medicaid RACs to audit Medicaid claims and to identify underpayments and identify and recover overpayments. We are concerned regarding the consistency of the execution of the programs, by potentially having multiple contractors within a state there will be challenges with supporting and managing these plans on a consistent basis. Currently, there is limited disclosure of Medicare guidelines for each state.

Recommendation: We encourage CMS to limit the number of audit contractors that can participate in the RAC initiative and require the States to publish their Medicaid guidelines to reduce confusion and improve understanding of the expectations by the States and providers.

Comment: The implementation date of April 1, 2011 is an extremely aggressive timeline in which to develop and implement a full production Medicaid RAC program. The operational Medicare program is still relatively new, per your statement [75 FR 69040] and there continues to be challenges with implementing this program and applying lessons learned from the RAC Demonstration program.

Recommendation: We encourage CMS to extend the implementation date of the program by several months. By postponing the implementation date CMS can engage in educational activities for the providers and the States, conduct outreach activities, allow opportunities to meet with RACs to ensure mutual understanding of expectations and serve as another avenue to provide education and awareness in order to reduce the number of mistakes/errors that are made.

§ 455.508 Eligibility requirements for Medicaid RACs.

Comment: AHIMA is pleased to note in the proposed regulation that CMS is requiring the employment of trained medical professionals, however we believe the requirements should also include and state the need for professionally certified coders with expertise in certain clinical subject areas (physician, hospital, etc.) to ensure proper alignment of skills and segment area. Comments received from our membership indicate many registered nurses (RNs) hired to review charts are not applying the official coding guidelines. HIM professionals spend much time writing letters to the current Medicare RACs to clarify why something was reviewed incorrectly by the RAC and to provide correct information.

Recommendation: AHIMA strongly recommends hiring professionally trained and certified coders, who have the appropriate skill sets would facilitate improved reviews and reduce duplicative work in reviewing records correctly.

Recommendation: AHIMA strongly recommends using the official coding guidelines that have been established and approved by CMS and the other organizations that make up the Cooperating Parties for the ICD-9-CM (the American Hospital Association (AHA), the American Health

Department of Health and Human Services
AHIMA Comments on Medicaid RAC proposed regulation
Page 3

Information Management Association (AHIMA) and the CDC's-National Center for Health Statistics (NCHS)). These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA under contract with CMS.¹

Recommendation: AHIMA suggests the final regulation specify the requirement to employ a licensed physician medical director to oversee and provide clinical expertise during the review and audit process.

Recommendation: AHIMA supports CMS' recommendation to have States establish requirements regarding the documentation of good cause to review a claim.

Recommendation: AHIMA believes the audit process would be further enhanced by developing consistent and objective review criteria for States to follow and have this information publicly available in order to establish a baseline for the community. Many providers experienced arbitrary Medicare RAC denials with no rationale for these denials. The lack of consistent and transparent guidelines led to confusion thus making it difficult to determine what the RAC contractors required in terms of information and slowing down the response process. The implementation of a consistent process would enable those facilities that reside on borders to apply guidelines consistently, thus reducing variations in the requirements.

§ 455.512 Medicaid RAC Provider Appeals

Comment: AHIMA supports CMS' requirement for States to establish an adequate appeals process enabling entities to challenge adverse Medicaid RAC determinations and we urge CMS to leverage lessons learned from the Medicare RAC program as much as possible. CMS is lacking on several critical factors and defined structure of the appeals process which we believe requires further clarification.

Recommendation: Develop a robust and consistent infrastructure to support the Medicaid RAC appeals process to reduce confusion and ambiguity experienced by providers. We suggest publishing this information online through a mechanism in which all parties engaged in the program experience a transparent and structured process.

Recommendation: AHIMA supports the ability for States to leverage existing and an improved appeals infrastructure, thus reducing burden and reducing ramp up time to develop and learn new processes. We encourage States to utilize existing processes.

¹ "ICD-9-CM Guidelines, Conversion Tables, and Addenda," Centers for Disease Control and Prevention, accessed January 4, 2011, http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.

Recommendation: AHIMA encourages CMS to establish reasonable timeframes in which RACs must respond to the facility during the appeals process. Our members experience has shown that RACs do not respond until several months later without any initial acknowledgement of receipt of communication. We believe the RACs must be held accountable in their response period as well in order to ensure timeliness in addressing denials or other issues.

Comment: AHIMA believes Medicaid RAC contractors must conduct due diligence in their review for the initial denial of complex claim review. HIM professionals' experience has shown a lack of review by the RAC contractor before they deny the review. Due to this, claims are taken to the next level of appeal resulting in unnecessary workloads. This is demonstrated by obvious cut and paste activities where the denial letters are disjointed, full of spelling and grammatical errors, and do not reflect the correct information as it relates to a specific claim. This behavior by the RACs demonstrates a lack of review, understanding, and due diligence on their part to take the appropriate amount of time and ensure their information is accurate before submitting a denial letter to the hospital.

Recommendation: We encourage CMS to hold the RAC contractors accountable and conduct due diligence by ensuring accurate and timely denial letters to a hospital currently under audit.

General Comments

Medical record requests – During the Medicare RAC demonstration program and without established record request limits, providers and hospitals received hundreds and sometimes several thousand requests in a short amount of time. Our members have indicated these requests created significant administrative burden and challenges in responding within the required timeframes. The inability to submit electronic copies also increased the burden to respond.

Recommendation: We strongly encourage CMS to outline in the regulation the following –

1. Ability to accept electronic copies of medical records such as CDs, a secure portal to upload information or other electronic media solution.
2. Establish a record request limit similar to that defined in the Medicare RAC program.
3. Pay for the copying and mailing of the records to offset costs associated with this process.

Duplicate audits – CMS acknowledges in the preamble of the proposed rule the potential challenges associated with implementing and coordinating the Medicaid RAC program audits with other agencies or entities that may be engaged with audits during this time.

Recommendation: We strongly encourage CMS to specify in the final regulation the exclusion of Medicaid RAC audits from records or claims that are under review by another agency or entity. We also believe claims that have been previously denied should be excluded from review to reduce duplicate work on behalf of the hospital.

Department of Health and Human Services
AHIMA Comments on Medicaid RAC proposed regulation
Page 5

Consistency and lessons learned – Through the Medicare RAC demonstration program there were significant challenges experienced by the provider community, thus CMS implemented changes to the production program in response to feedback received and experiences by the RACs.

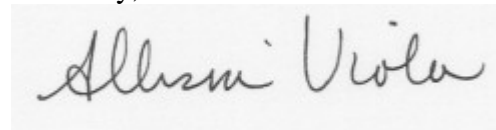
Recommendation: AHIMA encourages CMS to leverage those lessons learned from the demonstration program thereby reducing the opportunity to make similar errors or mistakes experienced from the RAC contractors. We believe the lack of record request limits initially established and lack of transparency of the guidelines represents lessons learned from the program, thus changes were implemented to ensure the program was more fair and equitable.

Recommendation: AHIMA encourages CMS to provide as much guidance as possible in the final regulation to support a consistent approach across the states. For those hospitals that reside in the corners of states, they will experience significant challenges trying to maintain situational awareness of the variables among the differing states thereby adding administrative burden on top of an administratively taxing process.

Recommendation: HIM professionals have been involved in the RAC program since its inception. As an association of these professionals, AHIMA is in a position to work with CMS in the on-going education and evaluation process that should be in place to ensure the RAC programs meets its goals without increased burden on the healthcare provider. We stand ready to work with you and your CMS staff to make the programs a positive one for all concerned. Likewise, our HIM professionals are members of a state health information management association, and we believe these HIM associations and their members are likewise ready to support and work with their state Medicaid agency to ensure the local RAC programs are implemented and maintained successfully.

If AHIMA can provide any further information or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or AHIMA's vice president, policy and government relations, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org. If we can be of further assistance to you in your efforts, we would welcome the opportunity to provide support.

Sincerely,



Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations