Eli's Rehab Report

Outpatient Outlook: Surprise: RACs to Perform Manual Medical Reviews for Therapy Claims Over $3700

Experts concerned that RACs get paid extra for every claim they deny.

Get ready to deal with Recovery Audit Contractors in more than one area of scrutiny. The **Centers for Medicare & Medicaid Services** has announced that for all outpatient therapy claims surpassing the $3,700 threshold, as of April 1, 2013, RACs will be conducting the manual medical reviews not your Medicare Administrative Contractor.

"We're pretty discouraged that CMS chose to involve the RACs," says **Jennifer Hitchon, JD, MHA**, counsel and director of regulatory affairs for the **American Occupational Therapy Association.**

RACs are paid on a contingency fee, which means they get a percentage of the dollars for denied claims.

"This could have a chilling effect on beneficiary access to care when providers are making decisions about surpassing the $3,700 threshold knowing that their reviewer is being paid on a contingency basis," Hitchon says.

The upside: Only four RACs across the country will be handling this process. "So there should be more uniformity because there were more [than four] MACs handling the process before," Hitchon says.

Also, "RACs have more automated systems," notes **Gayle Lee, JD,** senior director of health finance and quality for the **American Physical Therapy Association.** For example, RACs will have electronic portals where you can see when the RAC receives your information, as well as the claim's status (i.e. approved or denied), Lee says.

Determine If You're in a Prepayment or Post-payment Review State

All outpatient therapy claims above $3,700 will fall under manual medical review. You will not get a set number of approved therapy visits in advance as you did in 2012. "Each therapy visit will be reviewed to determine whether or not the services meet the medical necessity criteria under Medicare," Lee explains.

Critical: Last February, CMS introduced a prepayment review process, but now, only states under the RAC prepayment review demonstration will undergo prepayment review for their claims. These states include California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas.

All other states will undergo post-payment reviews. In this process, when the therapy dollar amount exceeds $3,700, your MAC will flag the claim. Your MAC will pay the claim automatically but will send you an additional documentation request (ADR). You'll send the documentation to your RAC, not your MAC, Lee explains. Then, "the RAC will conduct post-payment review and notify the MAC of its final decision."

"CMS is trying to eliminate the cash flow issue for providers [with post-payment review], but there is still certainly risk for the provider [to have their payment rescinded]," Hitchon points out.

Keep an Eye on Your RAC's Timeframes

Providers in post-payment review states get paid upfront, but those in prepayment review states will wait longer. RACs, however, must conduct the prepayment review within 10 business days of receiving the ADR.

Concern: "In Q4 of 2012, when the MACs were doing this process, providers were not hearing back within 10 business

days, and we don't have any reason to suspect that the RACs will be better, so we're watching this closely," Hitchon says.

For post-payment reviews, CMS is giving RACs up to 45 days to make a determination.