Understanding RAC Audit Trends

Audio Seminar/ Webinar
November 4, 2008

Practical Tools for Seminar Learning
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Faculty

Gloryanne Bryant, RHIA, CCS

Gloryanne Bryant is corporate senior director of coding HIM compliance for CHW, where she is responsible for coding and documentation compliance of 40 acute care facilities and a variety of other non-hospital healthcare entities in three states. Ms. Bryant has over 28 years of experience in the HIM profession. She is a sought-after national speaker and author, and serves as a catalyst for change in healthcare.

Laura Pait, RHIA, CCS

Laura Pait is senior manager with the healthcare consulting group of Dixon Hughes PLLC in Apex, NC. Ms. Pait has over 20 years of business consulting experience with hospital organizations. She is also a frequent presenter of educational seminars on coding fundamentals and operational efficiencies.
<table>
<thead>
<tr>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
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</tr>
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</tr>
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</tr>
</tbody>
</table>

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(CONTINUED)
Goals & Objectives

- Identify the Inpatient Diagnoses Trends
- Identify the Outpatient Hospital Trends
- Identify issues and concerns for Rehab and Physician Practices
- Understand how RAC determinations will affect revenue

Polling Question #1

Has your hospital, health system or practice created a RAC Task Force or Committee yet?

*1 Yes
*2 No
*3 Don’t know
Medicare Facts… Put Things into Perspective… It’s Complex!

- The Medicare Fee-for-Service (FFS) program consists of a number of payment systems, with a network of contractors that process over 1.2 billion claims each year.
- These are submitted by more than 1 million health care providers such as hospitals, physicians, skilled nursing facilities, labs, ambulance companies, and durable medical equipment (DME) suppliers. (Source: Medicare RAC Demonstration Report 7/08)

Polling Question #2

- How much money does CMS spend annually on government funding, beneficiary premiums, and other resources for Medicare?
  * 1. 100 billion
  * 2. 200 billion
  * 3. 356 billion
  * 4. 456 billion
**RAC Legislation Background**

- Medicare Modernization Act Section 306:
  - required RAC demonstration
- Tax Relief and Healthcare Act of 2006, Section 302:
  - requires permanent and nationwide RAC program by no later than 2010
  - *Both statutes gave CMS the authority to pay RACs on a contingency fee basis.*
RAC Timeframe

<table>
<thead>
<tr>
<th>Claims Available for Analysis</th>
<th>Provider Outreach</th>
<th>Earliest Correspondence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 15, 2009</td>
<td>Feb 2009</td>
<td>Mar 1, 2009</td>
</tr>
<tr>
<td>Jun 15, 2009</td>
<td>Jul 2009</td>
<td>Aug 1, 2009</td>
</tr>
</tbody>
</table>

RAC Contacts
RAC 1-800 lines are not operational; Once operational all phone numbers will be posted at www.cms.hhs.gov/ rac

<table>
<thead>
<tr>
<th>RAC</th>
<th>CMS Contact Person</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>DCS</td>
<td>Ebony Brandon</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Ebony.Brandon@cms.hhs.gov">Ebony.Brandon@cms.hhs.gov</a></td>
</tr>
<tr>
<td>B</td>
<td>CGI</td>
<td>Scott Wakefield</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Scott.Wakefield@cms.hhs.gov">Scott.Wakefield@cms.hhs.gov</a></td>
</tr>
<tr>
<td>C</td>
<td>Connolly Healthcare</td>
<td>Marie Casey</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Marie.Casey@cms.hhs.gov">Marie.Casey@cms.hhs.gov</a></td>
</tr>
<tr>
<td>D</td>
<td>HealthDataInsights</td>
<td>Marie Casey</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:Marie.Casey@cms.hhs.gov">Marie.Casey@cms.hhs.gov</a></td>
</tr>
</tbody>
</table>

Source: CMS RAC Call 10/08
**RAC Demonstration Findings**

- RACs were given $317 Billion in claims paid
- RACs found $1 Billion in improper payments
- Most were overpayments collected from providers
- $37 million were underpayments repaid to providers
- Only 6.8% of RAC determination were overturned on appeal (as of 6/30/08)

**3 Keys to RAC Program Success**

- **Minimize Provider Burden**
  - Limit the number of medical record requests
  - Limit the RAC “look-back period”

- **Assure Accuracy**
  - Each RAC has a physician medical director
  - Each RAC has certified coders
  - New issue review board (greater oversight)
  - Independent validation contractor
  - Annual accuracy rates for each RAC

- **Maximize Transparency**
  - New issues posted to web (now)
  - Vulnerabilities posted to web (now)
  - RAC claim status website (by 2010)
RAC Lessons Learned

<table>
<thead>
<tr>
<th>Demonstration RACs</th>
<th>Permanent RACs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look back period (from claim pmt date - date of medical record request)</td>
<td>4 years</td>
</tr>
<tr>
<td>Maximum look back date</td>
<td>None</td>
</tr>
<tr>
<td>Allowed to review claims in current fiscal year?</td>
<td>No</td>
</tr>
<tr>
<td>RAC medical director</td>
<td>Not Required</td>
</tr>
<tr>
<td>Coding experts</td>
<td>Optional</td>
</tr>
<tr>
<td>Discussion with RAC medical director regarding claim denials if requested</td>
<td>Not Required</td>
</tr>
<tr>
<td>Credentials of reviewers provided upon request</td>
<td>Not Required</td>
</tr>
<tr>
<td>Vulnerability reporting</td>
<td>Limited</td>
</tr>
<tr>
<td>RAC must payback the contingency fee if the claim overturned at...</td>
<td>...first level of appeals</td>
</tr>
<tr>
<td>Web-based application that allows providers to customize address &amp; contact</td>
<td>None</td>
</tr>
<tr>
<td>External validation process</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

RAC Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
  - 10% of avg mthly Medicare claims (max of 200) per 45 days

- **Other Part A Billers (Outpatient Hospital, HH)**
  - 1% of average monthly Medicare services (max of 200) per 45 days

- **Physicians**
  - Solo Practitioner: 10 medical records per 45 days
  - Partnership of 2-5 individuals: 20 medical records per 45 days
  - Group of 6-15 individuals: 30 medical records per 45 days
  - Large Group (16+ individuals): 50 medical records per 45 days

- **Other Part B Billers (DME, Lab)**
  - 1% of average monthly Medicare services per 45 days
### 10/21/08 AHA News about RAC Record Requests...

- CMS discussed limits on medical record requests by RACs
- For inpatient claims, the maximum number of records RACs may request will vary by the hospital’s national provider identifier and will equal 10% of average monthly Medicare claims.

### 10/21/08 AHA News about RAC Record Requests...

- The RACs will not be able to request more than 200 records in a 45-day period for both inpatient and outpatient claims combined. Providers with more than one NPI may face a unique record limit per NPI; however, CMS staff said they plan to provide further clarification on this policy. Earlier this month, CMS announced the names of the permanent RACs and revised plans for the nationwide rollout. Hospitals in the first phase of the rollout may begin to receive requests for medical records or reimbursement of overpayments as early as December.
CMS’ Efforts to Reduce Medicare Improper Payments via RAC

- Data analysis
- Prepayment claim review
  - New edits (automated review)
  - Medical record review (complex review)
- Post-payment claim review
- New/clarified national policies
- Provider education
Automated RAC Issues - Outpatient and Inpatient Claims

- Excessive units of service
  - Pharmacy/drugs
  - Speech therapy
  - Outpatient surgery
- Discharge disposition
  - Found over & underpayments!
- Medically unnecessary services
  - Colonoscopy

CMS RAC Reports... (worth review)
CMS RAC Status Report (7/08)

- RACs collected $1.03 billion in improper payments during the three-year demonstration program; $992.7 million in overpayments and $37.8 million in underpayments.
  - After expenses, appeals and underpayments repaid to providers, the program returned $693.6 million to the Medicare Trust Fund.

- Hospitals accounted for 95 percent of overpayments collected by RACs
  - 85 percent from inpatient services
  - 4 percent from outpatient services
  - 6 percent from inpatient rehabilitation facilities.

CMS RAC Status Report (7/08)

- The overpayments nearly 40 percent were based on a RAC determination that care provided was not medically necessary or provided in the correct setting
  - 35 percent were denied for incorrect coding and 8 percent for no/insufficient documentation.

- 4.6 percent of all RAC denials were overturned through the appeals process.
  - 14 percent of RAC denials appealed as of June 08, approximately one-third were overturned in favor of the provider.
  - However, many denials are still in the appeals process, and final figures will not be available for some time. CMS will issue report updates through 2008 on appeals that are still in process.
**RAC Status Report**

Figure 5. Overpayments Collected by Provider Type:
Cumulative Through 3/27/08, Claim RACs Only

- **$59.7 Million** Inpatient Rehabilitation Facility 6%
- **$19.3 Million** Skilled Nursing Facility 2%
- **$16.3 Million** Outpatient Hospital 4%
- **$44.0 Million** Physician 2%
- **$5.4 Million** Ambulance/Lab/Other <1%
- **$6.3 Million** Durable Medical Equipment 1%

Note: These data are not net of appeals.
Source: RAC invoice files and RAC Data Warehouse (rates needed to calculate Physician percentages from Ambulance/Lab/Other data were self-reported by the Claim RACs).

**RAC Status Report**

**Appendix E**

**Overpayments Collected by Error Type and Provider Type**

<table>
<thead>
<tr>
<th>Error Type</th>
<th>Inpatient Hospital</th>
<th>Skilled Nursing Facility</th>
<th>Outpatient Hospital</th>
<th>Physician</th>
<th>Ambulance/Lab/Other</th>
<th>Durable Medical Equipment</th>
<th>Total Overpayments Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Necessity</td>
<td>34.50</td>
<td>9.63</td>
<td>0.26</td>
<td>0.47</td>
<td>0.00</td>
<td>0.00</td>
<td>40.86</td>
</tr>
<tr>
<td>Incorrectly Coded</td>
<td>30.48</td>
<td>0.00</td>
<td>0.62</td>
<td>2.64</td>
<td>1.05</td>
<td>0.06</td>
<td>34.66</td>
</tr>
<tr>
<td>No/Insufficient Doc</td>
<td>6.63</td>
<td>0.44</td>
<td>0.48</td>
<td>0.11</td>
<td>0.00</td>
<td>0.08</td>
<td>7.76</td>
</tr>
<tr>
<td>Other</td>
<td>12.57</td>
<td>0.00</td>
<td>0.41</td>
<td>1.22</td>
<td>1.44</td>
<td>0.45</td>
<td>16.72</td>
</tr>
<tr>
<td>Total</td>
<td>84.19</td>
<td>8.07</td>
<td>1.76</td>
<td>4.26</td>
<td>2.56</td>
<td>6.51</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-Reported by the Claim RACs.
Hospital Specific Audit Findings/Trends

Appendix F
Audit Areas and Top Errors by Provider Type

Figure F1. Audit Areas and Top Errors by Provider Type, Net of Appeals: Cumulative Through 3/27/08, Claim RACs Only (Percent of Overpayment Amount)

RAC Audit Findings/Trends
RAC Audit Findings/ Trends

Table P3. Wrong Principal Diagnosis (Complex Review, Incorrect Coding)

<table>
<thead>
<tr>
<th>Claim Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Principal diagnosis on claim did not match the principal diagnosis in the medical record.</td>
</tr>
<tr>
<td>• Example: respiratory failure (code 518.91) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis.</td>
</tr>
<tr>
<td>• The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded services and the amount for the correctly coded services.</td>
</tr>
<tr>
<td>• Most common DRGs with this problem:</td>
</tr>
<tr>
<td>● DRG 475 (respiratory system diagnoses)</td>
</tr>
<tr>
<td>● DRG 468 (extensive OR procedure unrelated to principal diagnosis)</td>
</tr>
</tbody>
</table>

Corrective Actions:

• Hospitals can be more careful when submitting claims for DRG 475 and 468 to ensure that they choose the correct diagnosis to list as principal.
• Medicare claims processing contractors can remind hospitals about the importance of listing the correct principal diagnosis on the claim, especially when listing for DRG 468 and 475.
• Providers and Medicare claims processing contractors can refer to the Federal Register, February 11, 1998 (Volume 63, Number 26) for guidance on the proper coding of nondiagnostic preadmission services.
• Also refer to the American Hospital Association’s definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.

RAC Audit Findings/ Trends

Table P4. Wrong Diagnosis Code (Complex Review, Incorrect Coding)

<table>
<thead>
<tr>
<th>Claim Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospital reported a principal diagnosis of 03.89 (sepsisemia)</td>
</tr>
<tr>
<td>• Medical record shows diagnosis of urinosis, not sepsisemia or sepsis. Blood cultures were negative</td>
</tr>
<tr>
<td>• Did not meet the coding guidelines for “sepsisemia.” Changing the diagnosis code to urinary tract infection (UTI) caused the claim to group to a lower DRG</td>
</tr>
<tr>
<td>• The RAC determined that the claim was INCORRECTLY CODED and issued a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure.</td>
</tr>
</tbody>
</table>

Corrective Actions:

• Hospitals can be more careful when submitting claims for sepsisemia.
• Medicare claims processing contractors can remind hospitals about the importance of listing an accurate principal diagnosis for beneficiaries with a UTI.
• Providers and Medicare claims processing contractors can refer to the Federal Register, February 11, 1998 (Volume 63, Number 26) for guidance on the proper coding of nondiagnostic preadmission services.
• Also refer to the American Hospital Association’s definitions of Principal diagnosis and Principal Procedure, found in the ICD-9-CM Official Guidelines for Coding and Reporting.
RAC DRG Audit Targets

- **Inpatient DRGs:**
  - **DRG 416**
    - PrDx (Principal Diagnosis) Sepsis or septicemia diagnosis
  - **DRG 217 or 263**
    - Procedure: Excisional Debridement code 86.22
  - **DRG 468**
    - Confirm PrDx compared to Pr (Principal) Procedure
  - **DRG 397**
    - Appropriate selection of the PrDx
  - **Single “CC” (Comorbid/Complication) DRGs**
    - Confirming the “cc” is appropriately assigned

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**CHW**

- Catholic Healthcare West, headquartered in San Francisco, CA, is a system of 42 hospitals and medical centers in California, Arizona and Nevada.
- Founded in 1986, CHW is the eighth largest hospital system in the nation and the largest not-for-profit hospital provider in California.
- CHW is committed to delivering compassionate, high-quality, affordable health care services in a compassionate environment that is attuned to every patient’s physical, mental and spiritual needs.
**CHW**

- The CHW network of more than 7,800 physicians and approximately 44,000 employees provides quality health care services during more than four million patient visits annually.
- In 2006, CHW provided more than $465 million in community benefit and free care for the poor.
- Three FI/MACs, only the FI NGS was involved in the RAC... 24 hospitals.

**CHW RAC DRG Targets**

<table>
<thead>
<tr>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>CODING</td>
<td>$</td>
<td>#</td>
</tr>
<tr>
<td>475 RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>415 O.R. PROCEDURE FOR INFECTIOUS &amp; PARASITIC DISEASE</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>076 OTHER RESP SYSTEM O.R. PROCEDURES W CC</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>515 CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATHER</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>217 WND DEBRID &amp; SKN GRFT EXCEPT HAND, FOR MUSCULOSKELETAL</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>456 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGN</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>283 SKIN GRAFT &amp;/OR DEBRID FOR SKN ULCER OR CELLULITIS</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>535 CARDIAC DEFIB IMPLANT W CARDIAC CATHER W AMI/HF</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>416 SEPTICEMIA AGE &gt;17</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>1271 HEART FAILURE &amp; SHOCK</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>145 MAJOR SMALL &amp; LARGE BOWEL PROCEDURES W CC</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>124 CIRCULATORY DISORDERS EXCEPT AMI W CARD CATHER</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>007 PERIPH &amp; CRANIAL NERVE &amp; OTHER NERV SYST PROC</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>088 SIMPLE PNEUMONIA &amp; PLEURISY W CC</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

Highest $ impact at the top - DRG 475 and descending
### CHW RAC DRG Targets: Inpatient Medical Necessity

<table>
<thead>
<tr>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL NECESSITY</td>
<td>$</td>
<td>#</td>
</tr>
<tr>
<td>515 CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>127 HEART FAILURE &amp; SHOCK</td>
<td>132</td>
<td></td>
</tr>
<tr>
<td>124 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATHER</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>115 PERMANENT PACEMAKER IMPLANT</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>315 OTHER KIDNEY &amp; URINARY TRACT O.R. PROCEDURES</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>089 SIMPLE PNEUMONIA &amp; PLEURISY W CC</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>118 CARDIAC PACEMAKER DEVICE REPLACEMENT</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>088 CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>524 TRANSIENT ISCHEMIA</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>132 ATHEROSCLEROSIS W CC</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>294 DIABETES AGE &gt;3 5</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>138 CARDIAC ARRHYTHMIA &amp; CONDUCTION DISORDERS W</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>116 OTHER PACEMAKER IMPLANT</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>139 CARDIAC ARRHYTHMIA &amp; CONDUCTION DISORDERS W</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>(36,074,631)</td>
<td>825</td>
<td></td>
</tr>
</tbody>
</table>

### CHW RAC Targets: Rehab Medical Necessity

<table>
<thead>
<tr>
<th>REHAB</th>
<th>$</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>482 REHABILITATION (includes nonDRG IRF)</td>
<td>($8,282,243)</td>
<td>464</td>
</tr>
</tbody>
</table>

Many were appealed and Significant reversals have now occurred
### CHW RAC Tracking - Statistics

<table>
<thead>
<tr>
<th>RAC (PRO SCHR) CHART REQUESTS</th>
<th>Not Change</th>
<th>Charts per Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4 STATISTIC September 24, 2008</strong></td>
<td></td>
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### CHW Hospital Specific RAC Findings

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<th>F</th>
<th>G</th>
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33

34
**Coding RAC Audit Issues: Excisional Debridement - 86.22 (ICD-9-CM Procedure Code)**

- Debridement performed in OR or at bedside
  - Physicians not explicitly documenting “excisional debridement”
    - “Sharp” is considered insufficient by RAC
    - “Excisional Debridement” is considered insufficient by RAC
    - Use of scissors not substantial without explicit “excisional” documentation
      - Educate your clinicians
      - May need to revise documentation forms

*1st Qtr 2008 – new guidance from AHA... review*

**Coding - RAC Audit Issues - Single “CC” DRGs**

- Target DRG where only (1) CC diagnosis was assigned
  - Documentation supporting code assigned
  - Example: 285.1 as single cc
Audit: Utilization Management Issues

- One day stay denials - medical necessity (meet criteria)
  - Cross section with PEPPER/ CERT data
    - Back Pain, DRG 243
    - Chest Pain, DRG 143
    - CHF, DRG 127
    - DRGs 182/ 183, Gastroenteritis

- Two day stay

- Three day stay - to SNF

Audit: InterQual Criteria - Medical Necessity Denial

- Inpatient Surgeries performed on Inpatients while not on the “Inpatient Only” list
  - Cardiac procedure
    - AICD
  - Changes to InterQual - Case Management unaware

- Need to establish UR/ Case Mgmt. involvement

- Medical Director review for clinical perspective
Audit: Medical Necessity Issues

- Admission for Inpatient Rehabilitation
  - RAC denying claims due to lack of meeting medical necessity criteria
    - Hip/knee replacement Dx
    - CVA/Stroke Dx
    - Other
  - Note: Other RACs did not pursue this issue
  - California Hospital Association active lobbying and suggested taking legal action
  - Many refunds have now been made

Audit: Other RAC Targets

- Lack of MD orders
  - No MD order to admit to inpatient status
- LAB
- Pharmacy Drugs
- Physician Services -
  - E&M visits
  - Procedures
- Also monitor and track these requests
Targeted RAC Reviews – “Data Mining”

- Use of proprietary data mining tools that identify cases with the greatest probability of change
  - Drills down from DRG assignment to
    - ICD-9-CM diagnosis and procedure codes
    - Charges
    - Length of stay
- You need to be “Data Mining” also

Polling Question #3

- Has your Hospital, Health System or Practice developed a RAC assessment strategy?
  *1 Yes
  *2 No
  *3 Under discussion
RAC Planning

Revenue Cycle Components

Pre-Encounter
1. Scheduling
2. Medical Necessity Determination
3. Pre-Registration
4. Registration and Demographic/Insurance Validation
5. Insurance Verification
6. Pre-Certification
7. Financial Counseling
8. Point of Service Collections

Encounter
9. Clinical Care/Documentation/Transcription
10. HIM
11. Coding
12. Charge Capture
13. Charge Entry
14. Charge Description Master
15. Billing Master
16. Case Management

Post-Encounter
17. Claims Preparation
18. Claims Submission
19. Third Party Follow-Up
20. Self-Pay Follow-Up
21. Rejection Processing
22. Payment Posting
23. Payment Validation
24. Denial and Appeal Management
25. Contracts
26. Bad Debt Management
A Compliant Process

Mechanics of the Process

- Steps in the Process
  - Initial Communication
  - Receive Requests
  - Respond to Requests
  - Notification of Outcome
  - Appeal Processes
  - Recoupment and claims adjustment process
Revenue Integrity Team

- Corporate Compliance-co-chair with HIM Director
- Health Information Management
- Case Management
- Finance/Revenue Mgmt.
- CDM
- Billing
- Medical staff
- Clinical departments

Define Goals and Responsibilities

- Ensure oversight by executive management
- Ensure engagement of departments and physicians
- Utilize Corporate Compliance for oversight
- Foster implementation of process change and improvement
A Comprehensive Compliance Assessment Provides:

Review of:
- Current Billing and Coding
- Policies and procedures
- Oversight responsibilities
- Employee training
- Monitoring and auditing
- Discipline and enforcement

Compliance Solutions

An effective compliance program includes all the applicable elements.

Basic Seven Elements
1. Written Policies & Procedures
2. Designation of the Compliance Officer & Comm.
3. Conducting Effective Training & Education
4. Developing Effective Lines of Communication
5. Enforcing Standards through Well-published Disciplinary Guidelines
6. Auditing & Monitoring
7. Responding to Detected Offenses and Developing Corrective Action Initiatives
Risk Assessment

- Perform in all areas
- Identify what your risks are
- Implement process change
- Perform “drill downs” on accounts noted from assessment for corrective action
- Specific, Measureable, Realistic

Compliance Solutions

- Defend your data
- Review RAC overpayment determinations to confirm that the reason for overpayment is valid and the amount of alleged overpayment is substantiated
- Develop internal “appeal” guidelines
- Identify revenue opportunities in RAC designated underpayments
- Data mine and conduct pre-emptive assessments
RAC Preparation

Create a Check List

- Start an internal/external assessment plan
- The revised statement of work limit claims that RAC contractors may review to those with dates of service from October 1, 2007 and forward.
- Identify and correct deficiencies
  - Educate physicians on documentation requirements
  - Educate coding and billing staff as needed
  - Engage case managers/documentation specialists on the medical necessity related issues
  - Educate stakeholders and board members
  - Establish Best Practices
Create a Check List

- Familiarize yourself on Medical Necessity issues for both Inpatient and Outpatient services
- Define your internal process for managing requests and appeals

Develop a Tracking System

Providers/hospitals should track & trend all requests from RAC

- Include date of request received
- Deadline for submitting claim
- Total pages copied
- Reason for denial, physician involved & coding/case management (medical necessity issue)
- List all code-specific data
- Use mail service with tracking & signature request
**Proactive Approach - Just What the Doctor Ordered**

- Data Analytics is a powerful tool to monitor potential problems.
- Perform focused coding & medical necessity audits now.
- Don't limit audits from external vendors to one time per year.
- Stay abreast of OIG's Work Plan.
- Be proactive & audit accounts RAC would target & review.
- Create RAC team that works for your facility.

**Prepare for Permanence**

- Policies and procedures to address all RAC-related notifications.
- Procedures should include:
  - Notification to clinical and reimbursement staff:
    - Requests for medical records.
    - Determinations.
  - Monitoring of Remittance Advices (RAs) for reimbursement and adjustment.
  - Maintenance of records of RAC review requests and all documentation and communication.

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**Prepare for Permanence**

- Needed to oversee these processes
- Perform various RAC-related tasks
- Clinical - handles questions of medical necessity
- Financial - assesses impact on overpayment and underpayment decisions
- Compliance Officer must be included

**Prepare for Permanence**

- Records of RAC review requests and activities should include:
  - Number of claims requested
  - Number of denied claims
  - Date of reimbursement or recoupment by CMS
  - The amount of reimbursement recouped
  - All communications between the facility and RAC
  - Status of appeals
  - Complete timelines
Prepare for Permanence

- Reassess:
  - Operations
  - Admission policies
  - Referrals of patients to rehabilitation
  - Overall provider services to minimize their vulnerability to RAC due to procedural and documentation deficiencies

Prepare for Permanence

- Should I appeal? Consider:
  - The benefit versus the cost of the appeal
  - The resources that would be required
  - The quality of the medical records, charts, and other documentation
  - The implications of challenging or not challenging the denials
  - The availability of clinical support and input
  - Whether legal counsel should be retained
  - Not challenging a RAC’s determination could have a negative impact on a facility’s policies and procedures by giving credence to the RAC and causing the facility to institute changes in its patient care.
Summary & Keys to Success

- Appeal in accordance with facility/corporate guidelines - do not be timid!
- Learn from RAC findings and institute departmental and organizational changes accordingly
Summary: Being Proactive … RAC DRG Targets

- Data Mining
- Focused audits/ review of Medicare records in the following DRGs will also be included in this review process, as they represent potential OIG target areas: DRGs 14/15/524, 89/79, 87, 296, 416/320, 468 and DRG 475
  • Cross-walk to MS-DRGs
- Select a minimum of 3-4 charts from each of these DRGs will be selected for review.
- RAC focused DRGs will also be selected, DRG 217, 263, 397 and those with procedure code 86.22.
- In addition, single “cc” DRGs should also be selected for review.

Summary & Keys To Success

- Requires high level of collaboration, coordination and organization amongst HIM, Case Management, PFS and Administration
- Requires provision of necessary resources for HIM, CM and PFS
- Response to RAC requests and responses must be timely
- Tracking
Summary: Key Stakeholders for your Hospital RAC Task Force/Committee

1. HIM & Coding
2. Finance & Revenue Cycle
3. Patient Financial Services (PFS)
   1. Business office
4. Compliance
5. Case Management/Utilization Review

Who will be or serve as the RAC “Hub”?

---

Summary

Appendix R
Key Dates

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
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<tr>
<td>Congress passes Section 309 of the Medicare Modernization Act requiring</td>
<td>December 2003</td>
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<td>the use of RACs</td>
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<tr>
<td>CMS announces RAC demonstration</td>
<td>January 2005</td>
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<tr>
<td>CMS releases Requests for Proposals (RFPP) for NY, FL, and GA</td>
<td>January 2005</td>
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<tr>
<td>CMS aligns contracts for Claim RACs in NY, FL, and CA and MSP RACs in</td>
<td>March 26, 2005</td>
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<td>FL and CA</td>
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<td>RACs begin releasing significant overpayment notifications</td>
<td>January 2006</td>
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<td>CMS signs contract for MSP RAC in NY</td>
<td>February 23, 2006</td>
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<td>FY 2006 Status Document released</td>
<td>November 18, 2006</td>
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<td>Congress passes Section 302 of the Health Care Act of 2006, which</td>
<td>December 2006</td>
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<td>requires the RAC program to be made permanent and implemented nationally</td>
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<tr>
<td>CMS releases Request for Information and draft Statements of Work for</td>
<td>March 16, 2007</td>
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<td>4 permanent RACs</td>
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<tr>
<td>CMS signs contract for demonstration: Claim RACs to expand to MA, SC,</td>
<td>June 2007</td>
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<tr>
<td>and AZ</td>
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<td>RFPP for RAC permanent program released</td>
<td>October 19, 2007</td>
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<td>Proposals due from bidders wishing to become a permanent RAC</td>
<td>December 17, 2007</td>
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<tr>
<td>RAC demonstration ends</td>
<td>March 27, 2008</td>
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<tr>
<td>Release Demonstration Evaluation Report</td>
<td>June 2008 (anticipated)</td>
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<td>Award national RAC contracts</td>
<td>TBD</td>
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<tr>
<td>Begin provider outreach in summer 2008 RAC States</td>
<td>TBD</td>
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**Resource/Reference List**

**AHA RAC AudioConference - September 2008**  
http://www.aha.org/aha/issues/RAC/educational.html  
RACinfo@aha.org

**July, 2008 RAC Status report**  
www.cms.hhs.gov/RAC  
kimberly.brandt@cms.hhs.gov

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**Audience Questions**
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Appendix

Resource/Reference List ........................................................................................................... 39
RAC Acronyms/Abbreviations and Dispelling Myths
CE Certificate Instructions
Appendix

Resource/ Reference List

http://www.aha.org/aha/issues/RAC/educational.html

RACinfo@aha.org


www.cms.hhs.gov/RAC

kimberly.brandt@cms.hhs.gov
RAC Acronyms and Abbreviations

- **ALJ**: Administrative Law Judge
- **CAFM**: Contractor Accounting Financial Management System
- **CMD**: Contractor Medical Director
- **CMS**: Centers for Medicare & Medicaid Services
- **Connolly**: Connolly Consulting (the New York and Massachusetts Claim RAC)
- **CPT**: Current Procedural Terminology
- **DCS**: Diversified Collections Services (the California MSP RAC)
RAC Acronyms and Abbreviations

- **DHHS**: Department of Health and Human Services
- **DME**: Durable Medical Equipment
- **DOJ**: U.S. Department of Justice
- **DRG**: Diagnosis Related Group
- **ERRP**: Error Rate Reduction Plan
- **FFS**: Fee-for-Service
- **HCFA**: Health Care Financing Administration
- **HCPCS**: Healthcare Common Procedure Coding System
RAC Acronyms and Abbreviations

- **HDI**: Health Data Insights (the Florida and South Carolina Claim RAC)
- **IRF**: Inpatient Rehabilitation Facility
- **LCD**: Local Coverage Determination
- **MAC**: Medicare Administrative Contractor
- **MMA**: Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- **MSP**: Medicare Secondary Payer
- **NCD**: National Coverage Determination
RAC Acronyms andAbbreviations

- **NDNH**: National Database of New Hires
- **OIG**: Office of Inspector General
- **OMB**: Office of Management and Budget
- **PRG**: PRG-Schultz (the California and Arizona Claim RAC)
- **PSC**: Program Safeguard Contractor
- **QIC**: Qualified Independent Contractor
- **QIO**: Quality Improvement Organization
RAC Acronyms and Abbreviations

- **RAC**: Recovery Audit Contractor
- **RFP**: Request for Proposals
- **RVC**: RAC Validation Contractor
- **SNF**: Skilled Nursing Facility
- **TRHCA**: Tax Relief and Health Care Act of 2006
- **VDSA**: Voluntary Data Sharing Agreements
## Dispelling The RAC Myths

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<tr>
<th>Myth</th>
<th>Fact</th>
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<td>RACs make up their own rules &amp; policies</td>
<td>RACs use the same policies as the Medicare claims processors</td>
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<tr>
<td>RACs use unqualified staff</td>
<td>RACs use nurses, therapists &amp; coders and each has a Medical Director</td>
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<tr>
<td>All RAC reviews are done by “black box” computer edits</td>
<td>Much RAC review involves clinician review of medical records</td>
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<tr>
<td>RACs will replace QIOs</td>
<td>The job of educating hospitals about how to avoid submitting future claims with incorrect coding or medical necessity errors will remain with QIOs and FI s/ MACs</td>
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