Update on RAC Audits

Audio Seminar/ Webinar
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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.
Faculty

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Ms. Hirschl is president of Hirschl and Associates, where she develops, implements, and manages service that addresses best practices in revenue management and clinical data integrity. Nancy has over 25 years of experience in HIM, and has worked for numerous national healthcare organizations.

Leslie C. LaStofka, RHIA

Ms. LaStofka is the HIM director and privacy official at Sequoia Hospital in Redwood City, CA. She has over 25 years experience as an HIM director at both the local and regional levels. Her dynamic, results-oriented leadership has led to the development of a number of best practices shared across Catholic Healthcare West, Sequoia's parent company.
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Objectives

• Gain a comprehensive understanding of the inner workings of the RAC Program and its financial and operational impact on providers

• Identify strategic plans for RAC readiness

• Determine best practices for RAC management

Impact on Providers

Plain and Simple... Costly
Hospital Payment Errors

- Account for 94% of RAC Recoveries

Incorrect Coding and Medical Necessity

- Accounted for 74% of RAC Recovered Overpayments
### RAC Error Types

#### Top Services with RAC-Initiated Overpayment Collections (NET OF APPEALS) – FY 2007

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Description of Item or Service</th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Overturned on Appeal</th>
<th>Location of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td>Excisional Debridement</td>
<td>$20.5 m</td>
<td>$3.2 m</td>
<td>$2.5 m</td>
</tr>
<tr>
<td></td>
<td>IRF services following joint replacement surgery</td>
<td>$20.8 m</td>
<td>1,833</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>Heart Failure and Shock</td>
<td>$7.8 m</td>
<td>835</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td>$2.0 m</td>
<td>306</td>
<td>CA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$9.5 m</td>
<td>2190</td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surgical Procedures in Wrong Setting</td>
<td>$17.1 m</td>
<td>1,810</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td>Respiratory System Diagnoses with Ventilator Support</td>
<td>$9.5 m</td>
<td>577</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td>$4.1 m</td>
<td>266</td>
<td>CA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1.7 m</td>
<td>123</td>
<td>FL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extensive OR procedures Unrelated to Principal Diagnosis</td>
<td>$3.9 m</td>
<td>259</td>
<td>NY</td>
</tr>
<tr>
<td></td>
<td>$1.5 m</td>
<td>123</td>
<td>CA</td>
<td></td>
</tr>
</tbody>
</table>

### RAC Error Types

- **Top Hospital Outpatient Services with RAC-Initiated Overpayments**

<table>
<thead>
<tr>
<th>Description of Item or Service</th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Overturned on Appeal</th>
<th>Location of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital</td>
<td>Colonoscopy</td>
<td>$2.0 m</td>
<td>5,134</td>
</tr>
<tr>
<td></td>
<td>Speech Language Pathology Services</td>
<td>$1.4 m</td>
<td>3,296</td>
</tr>
<tr>
<td></td>
<td>Infusion Services</td>
<td>$1.3 m</td>
<td>9,956</td>
</tr>
</tbody>
</table>
RAC Error Types

- Top SNF and Physician Services with RAC-Initiated Overpayments

<table>
<thead>
<tr>
<th></th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Cases Overturned on Appeal</th>
<th>Location of Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>Physical Therapy and Occupational Therapy</td>
<td>$1.9 m</td>
<td>1,591</td>
</tr>
<tr>
<td></td>
<td>Speech Language Pathology Services</td>
<td>$1.5 m</td>
<td>2,690</td>
</tr>
<tr>
<td>Physician</td>
<td>Pharmaceutical Injectables</td>
<td>$2.0 m</td>
<td>9,534</td>
</tr>
<tr>
<td></td>
<td>Duplicate Claims</td>
<td>$1.8 m</td>
<td>15,925</td>
</tr>
<tr>
<td></td>
<td>Vestibular Function Tests</td>
<td>$1.4 m</td>
<td>13,608</td>
</tr>
</tbody>
</table>

Appeals Process

- Time Consuming and Costly, but May Be Worth the Effort

- 44% of Appealed Claims resulted in “Decision in Provider’s Favor”
  - 46.7% in NY
  - 4.1% in CA
RAC Identified Improper Payments

Summary of Total Improper Payments Corrected By The RAC Program – FY 2007

<table>
<thead>
<tr>
<th>State</th>
<th>Overpayments Collected</th>
<th>Underpayments Repaid</th>
<th>Total Improper Payments Corrected</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>$112.5 m</td>
<td>+ $1.8 m</td>
<td>= $114.3 m</td>
</tr>
<tr>
<td>Florida</td>
<td>$124.6 m</td>
<td>+ $4.1 m</td>
<td>= $128.7 m</td>
</tr>
<tr>
<td>California</td>
<td>$120.1 m</td>
<td>+ $8.4 m</td>
<td>= $128.5 m</td>
</tr>
<tr>
<td>Total</td>
<td>$357.2 m</td>
<td>+ $14.3 m</td>
<td>= $371.5 m</td>
</tr>
</tbody>
</table>

SOURCE: RAC Data Warehouse. m = million

RACs Only Recovered 0.2% of Estimated Improper Payments. Why?

“Each RAC indicated that if it were to become a permanent Medicare RAC, then it would likely hire more staff, to conduct more reviews, and correct more improper payments. Second, CMS prohibited RACs from reviewing certain types of claims for administrative simplification purposes (e.g., physician visit claims, home health and hospice claims, etc). Third, RACs were sensitive to the financial impact they were having on individual providers.”
RAC Impact to Providers

- Over 90% of the CA, FL, and NY hospitals had their Medicare revenue impacted by less than 2.5%

RAC Going National

Note: All dates are flexible
The MAC - Medicare Administrative Contractor

CMS has also developed a strategy so that the RAC program will not interfere with the transition from the old Medicare claims processing contractors to the new Medicare claims processing contractors called Medicare Administrative Contractors (MACs). This strategy will allow the new MACs to focus on claims processing activities before working with the RACs.

Generally, the RAC blackout period will be:
- 3 months before a MAC begins processing claims for a given state
- 3 months after a MAC begins processing claims for a given state

MAC Impact - Long Term

- Combine FI and Carrier functions
- Share access to and compare:
  - Hospital and Physician claims data
- Impact of RAC on MAC
  - Denied hospital inpatient claims
  - Review of physician claims for denied inpatient services
MAC Impact - Long Term

- May finally provide linkage between physician and hospital
  - Denied hospital claim may link with physician claim for inpatient services
- Should help to improve physician interest in hospital documentation and case management practices.

Polling Question #1

Has your hospital/health system created a RAC Team yet?

* 1 Yes
* 2 No
* 3 Don’t know
How The RAC Program Works

Automated Reviews
Outpatient & Some Inpatient Claims

- Claims data scrubbed
- Errors identified
- Provider reviews RAC findings
  - Routinely agrees with all changes
- Overpayments offset from incoming Medicare payments
Automated RAC Issues
Outpatient and Inpatient Claims

- Excessive units of service
  - Pharmacy/drugs
  - Speech therapy
  - Outpatient surgery

- Discharge disposition

- Medically unnecessary services
  - Colonoscopy

Automated RAC Claim Errors

Example of an “Excessive Units” Automated Review Audit

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Procedure</th>
<th>Units</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/04</td>
<td>47562</td>
<td>3</td>
<td>$2,461.23</td>
</tr>
</tbody>
</table>

CLAIM FACTS
- Procedure code 47562 is billed and paid with 3 units of service
- Same date of service, same beneficiary for all 3
- Units should never exceed 1 for a single date of service
- Overpayment amount: $1,221
- Error Type: Medical Necessity

CORRECTIVE ACTIONS
- Hospitals can be more careful when submitting claims for multiple units of service
- Medicare can add edits to the claims processing systems to disallow these "medically unbelievable" situations

Source: the Florida RAC

19


Automated RAC Claim Errors

Table C-6
Colonoscopy (Automated Review, Medically Unnecessary Services)

- The hospital billed for multiple colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) for the same beneficiary the same day.
- Beneficiaries never need more than one colonoscopy per day. The excessive services are NOT MEDICALLY NECESSARY.
- The RAC issued overpayment request letters for the difference between the billed number of services and 1.

Corrective Actions
- Hospitals can be more careful when submitting claims for colonoscopies (45355, 45378, 45380, 45383, 45384, 45385) to ensure they do not bill for more than one per day per beneficiary.
- Medicare claims processing contractors can remind hospitals about the importance of listing the accurate number of “units of service” on a claim.

Example of “Incorrect Discharge Status” Automated Review Audit

<table>
<thead>
<tr>
<th>Dates of SVC</th>
<th>Discharge Status Code</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/21 – 23/04</td>
<td>01 (home)</td>
<td>$2,606.00</td>
</tr>
<tr>
<td>8/23 – 27/04</td>
<td>02 (hospital)</td>
<td>$2,526.10</td>
</tr>
</tbody>
</table>

CLAIM FACTS
- Two different claims; two different providers
- Beneficiary was transferred from one hospital to another
- Claim #1 should have been billed with a discharge status of 02 (hospital). If it had been, it would have been paid at a per diem rate, rather than the DRG rate.
- Overpayment amount: $1,504.00
- Error Type: Incorrect Coding

CORRECTIVE ACTIONS
- Hospitals can be more careful when submitting claims with respect to the Discharge Status code
- Medicare claims processing contractors can remind hospitals about the importance of listing an accurate discharge status.

Source: The Florida RAC
Complex Audits
RAC Record Requests

- RAC sends Medical Record Request Letters for Complex Reviews
  - Hospitals have 45 days to submit copied charts
    - Should assess a .12 cents per page
      - Photocopy charge

Complex RAC Issues

- DRG assignment
- Medical Necessity and Low Length of Stay
- Surgeries performed as Inpatients while not on the “Inpatient Only” list
- Cancelled inpatient procedures
- Incongruent Charges to Payment Variances
- Cases with three day lengths of stay transferred to SNF
- Cases re-admitted within 72 hours
RAC Record Requests

- Medical Record Request Limit
  - Different limits for different provider types
  - Hospitals limit may be based on bed-size
    - May also take into account annual Medicare payments
  - The limit would be per provider location and type per time period
    - Example: No more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45 day time period
    - No “bunching” of request letters
**Physician Query Process**

- Enhance Physician Query Process
  - Pre discharge
  - Post discharge
- Understand RAC policies
  - Some RACs state that retrospective physician queries are not acceptable as supporting documentation when presenting rebuttals for “old” cases.
  - Note: Concentra allowed retro MD queries in California
- Acknowledge Impact on AR

**RAC Responses**

- RAC notifies hospital of decision within 60 days
- “Demand Letters” are sent when an overpayment is identified with reason for determinator
  - RAC advises hospital of Right of Appeal
**Update on RAC Audits**

### Underpayments

- RAC submits corrected data to FI
- Hospital receives corrected payment
- Hospital has no official appeals rights
  - RAC rebuttal process
  - If the provider disagrees with the RAC that an underpayment exists, the RAC shall defer to the billing provider’s judgment and request that the FI or carrier “undo” the underpayment
  - In addition, the RAC shall forward all supporting documentation, including the validation from the FI or Carrier to the CMS Project Officer or his/her delegate.

### Overpayments

- Hospitals can:
  - Agree with RAC determination
    - FI “withholds” overpayment $$ until “debt” is repaid
      - Cash flow preparedness - “Reserve planning”
  - Submit a rebuttal letter
    - Provider identify grounds for disagreement
    - RAC has 60 days to respond
  - Engage in appeal if rebuttal is over-turned
    - Take to CMS
    - Risk, but may be worth taking
Appeals Process

• Same as the regular appeal process except:
  • Inpatient hospital claim appeals go to FI (not QIO)
  • Rebuttal/Period of Discussion - 15 days
    • Rebuttal - To RAC
    • 1st level of appeal - To FI/Carrier/DMAC
    • 2nd level of appeal - To QIC
    • 3rd level of appeal - To ALJ
**Targeted RAC Reviews**

- 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
**RAC Data Mining Sources**

- MedPAR
- PEPPER
  - 1-2 day stay
  - 3 day to SNF
  - OIG targets
- CERT
- OTHER....

**More Complex With MS-DRGs**

<table>
<thead>
<tr>
<th>I-9 Procedure codes</th>
<th>MS-DRG</th>
<th>Description</th>
<th>RW</th>
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<tbody>
<tr>
<td>86.22, 77.69</td>
<td>463</td>
<td>Wnd debrid &amp; skin grft exc hand, for musculo-conn tiss dis</td>
<td>3.9615</td>
</tr>
<tr>
<td>86.22, 77.69</td>
<td>464</td>
<td>Wnd debrid &amp; skin grft exc hand, for musculo-conn tiss dis</td>
<td>2.8821</td>
</tr>
<tr>
<td>86.22, 77.69</td>
<td>465</td>
<td>Wnd debrid &amp; skin grft exc hand, for musculo-conn tiss dis</td>
<td>2.3417</td>
</tr>
<tr>
<td>77.69</td>
<td>495</td>
<td>Local excision &amp; removal int fix devices exc hip &amp; femur w MCC</td>
<td>2.5765</td>
</tr>
<tr>
<td>77.69</td>
<td>496</td>
<td>Local excision &amp; removal int fix devices exc hip &amp; femur w CC</td>
<td>1.7792</td>
</tr>
<tr>
<td>77.69</td>
<td>497</td>
<td>Local excision &amp; removal int fix devices exc hip &amp; femur w/o CC/MCC</td>
<td>1.2301</td>
</tr>
<tr>
<td>86.28</td>
<td>592</td>
<td>Skin ulcers w MCC</td>
<td>1.455</td>
</tr>
<tr>
<td>86.28</td>
<td>593</td>
<td>Skin ulcers w CC</td>
<td>1.106</td>
</tr>
<tr>
<td>86.28</td>
<td>594</td>
<td>Skin ulcers w/o CC/MCC</td>
<td>0.9335</td>
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Polling Question #2

What department in your organization has been designated to serve as the RAC “Hub”?  

*1  HIM  
*2  Finance  
*3  Compliance  
*4  Case Management  
*5  Not yet designated

RAC Blueprint for Survival

What, How, and When To Dos
The House That RAC Built

Residence - Mandatory

The RAC Blueprint

- **Laying the Foundation**
  - What your organization must know
- **Designing the Floor Plan**
  - Creating the RAC Team
- **Framing**
  - Organizational Deployment
  - Workflow Management
  - Database Management
**RAC Infrastructure**

- **Structural Inspection**
  - Risk Assessment/Financial Forecasting
- **Insulation and Insurance**
  - Transactional auditing

**RAC Readiness**

- **Open House**
  - RAC’s arrival
SEQUOIA HOSPITAL
Who Are We?

- 301 licensed bed acute care, community hospital located in Redwood City, CA
- Member of Catholic Healthcare West (42 hospital system serving CA, AZ and NV)
- Major service lines include Cardiovascular, Interventional Radiology, General Surgery, OB/GYN, Orthopedics, Behavioral Health, Radiation/Oncology

SEQUOIA HOSPITAL
Annual Utilization

- Admissions 10,221
- Patient Days 44,167
- Medicare Volume 40%
- Emergency Dept. Visits 18,634
- Outpatient Visits 114,692
RAC Audit Activity Summary

Demonstration Program

- DRG/coding RAC review requests from PRG Schultz:
  November 2005 - December 2007

- Dates of Service Reviewed: 2001 - 2005

- Total cases reviewed for DRG/coding: 929
  90% no change
  Appealed 30% of proposed changes
  Won 88% of appeals

RAC Audit Activity Summary

- Total cases reviewed for Medical Necessity:
  - 420
    - Large number of denials
    - Currently under appeal

- Denials primarily due to:
  1. lack of physician order for inpatient services
  2. inpatient InterQual criteria not met/not documented
**RAC Audit Activity Summary**

- **HIM Resources Required**
  - DRG and MN Requests: 1349 or 54/month
    - Approx. 40 hours clerical/month
    - Approx. 12 hours technical/ mgmt/ month
  - **TOTAL: .33 FTE**

**First Steps**

- Engage a multidisciplinary team
  - HIM, Case Mgmt, PFS, Pt Access, Admin
- Determine lead facility contact(s) for RAC representatives and local facility staff
  - HIM Director
- Determine how RAC medical record requests will be managed
  - Centralized through HIM
**Next Steps**

- Establish facility/corporate RAC Audit tracking spreadsheet in shared location
  
  *on shared “I” drive*

- Determine who will be responsible for updating spreadsheet
  
  *HIM, Case Mgmt, PFS*

**Managing RAC Requests**

HIM Processing Responsibility

- **Receive request, date-stamp and log into ROI**
- **Pull and copy charts**
- **Invoice at $0.12/page**
- **Mail charts via Fed-Ex or copy service**
  
  Best to be timely – easier to manage volume
  
  *(CMS allows 45 days – we submitted within 14)*
Managing RAC Requests

HIM Documentation Responsibility
RAC Spreadsheet

- Hospital Name (SEQ)
- Request date
- CPS/Control Number
- Account Number
- Medical Record Number

Managing RAC Requests

HIM Documentation Responsibility
RAC Spreadsheet
- Admit and Discharge Dates
- LOS
- Audit Type: Coding / Medical Necessity
- DRG Originally Assigned / Billed
- Date Chart Sent to RAC
Managing RAC Responses

HIM Process Responsibility

• Receive RAC response
• Separate into Coding/ Case Mgmt responses
• Enter initial finding on RAC spreadsheet
• Notify Case Management if requires CM review (medical necessity, patient status, etc.)
• If proposed DRG change, provide case to coder for review
• Update spreadsheet: no change or proposed DRG/ MN change

Managing RAC Responses

Case Management Process and Documentation Responsibility

• Review RAC findings letter
• Review chart
• Details of case review
• Accept RAC finding
• Appeal RAC finding (corporate guidelines)
• Appealed to
• Date of appeal
• Response to appeal
Managing RAC Responses

PFS Documentation Responsibility - Financial Information:

- Total Charges
- Total Medicare Payments
- Total Adjustments
- Estimated Take-Backs (HIM provided)
- Actual Take-Back Amount
- Actual Take-Back date
- Credits

Collaboration with RAC Auditors

- PRG Schultz left voice message with HIM when medical record requests were being faxed
- PRG Schultz left voice message when review responses were being faxed or mailed
- Specific RAC auditor always responded within 24 hours of phone call
- Involved coders in case discussion with auditors
- Rapport developed with central office
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

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
Step 1 - RAC Risk and Reward Reporting (R4) Services

R. RAC RISK AND REWARD REPORTS

REPORT 1 - Medical Necessity and Complex Coding Review Report

NEW DRGs TO BE REVIEWED

DRG 291
DRG 292
DRG 293

DRG Distribution Analysis National Averages — 50th Percentile

<table>
<thead>
<tr>
<th>DRG</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
<th>Cases @ National</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG 291</td>
<td>150</td>
<td>215</td>
<td>350</td>
<td>500</td>
</tr>
<tr>
<td>DRG 292</td>
<td>200</td>
<td>300</td>
<td>450</td>
<td>600</td>
</tr>
<tr>
<td>DRG 293</td>
<td>100</td>
<td>200</td>
<td>350</td>
<td>500</td>
</tr>
</tbody>
</table>

The 50th percentile level for each DRG grouping is calculated. Half of the Hospitals in this group are above this distribution and half are below.

Potential Underpayments

RAC Coding and Medical Necessity issues

Step 1 - RAC Risk Assessment

% Medicare Discharges vs % RAC Target DRG Volume

The General Medical Center

% Medicare % of Discharges Score
**Insulation and Insurance**

**Transactional Auditing**

**% Medicare Discharges vs % RAC Target DRG Volume**

**OLD DRG IDENTIFIED UNDER RAC AUDITS**

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>475</td>
<td>Respiratory System Diagnosis with ventilator support (Version 23 - 2006)</td>
</tr>
</tbody>
</table>

**NEW DRG List**

- **Dr. Respiratory System Diagnosis with ventilator support (96+ hours)**
- **Dr. Respiratory System Diagnosis with ventilator support (<96 hours)**

**DRG Distribution Analysis CBSA**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% CBSA</th>
<th>% Hospital Var Cases @ Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66.4%</td>
<td>55.2% 8.8% 14 No</td>
</tr>
<tr>
<td></td>
<td>36.0%</td>
<td>44.8% -8.8% 11 No</td>
</tr>
</tbody>
</table>

The CBSA analysis highlights the differences within the local market between the cases treated by the hospital and those of other facilities within the CBSA. This can indicate either a unique service or a significant departure from local coding and documentation levels if significant variances exist.

**Key Diagnosis Codes For DRG Change if present as secondary diagnosis**

- 428.xx
- 410.x1
- 785.5
- 785.51
- 038
- 433.11
- 433.81
- 433.91
- 434.01
- 434.11
- 434.91
- 433.01
- 433.21
- 433.31

**Cases with a Key diagnosis Code**

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>207</td>
<td>16</td>
</tr>
<tr>
<td>208</td>
<td>9</td>
</tr>
</tbody>
</table>

**Total Cases**

- 25

**Key Procedure Codes for DRG Change (with LOS qualifier)**

- 96.70 with LOS > 10 days
- 97.71 with LOS > 10 days
- 96.72 with LOS < 5 days

**Cases with a Key procedure code**

- 13

For cases with these codes and LOS, a review should be performed to validate the principal diagnosis code assigned based on documentation.

**Permanent Program Improvements**

- **Maximum look-back date:** 10/1/2007
- **Look-back period:** 3 years
  (from claim payment date to date of medical record request)
Permanent Program Improvements

- Coding Experts mandatory

- RAC Medical Director mandatory

- Allowed to review claims in current fiscal year

Permanent Program Improvements

- Limits on number of medical records
- Must pay hospital for medical record photocopying within 45 days of receipt of medical record
Resource/ Reference List

February, 2008 RAC report:

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Upcoming Seminars/ Webinars

Managing the CMI under MS-DRGs
Facility: Gloryanne Bryant, RHIA, RHIT, CCS
May 15, 2008

Benchmarking Coding Quality
Facility: Rose Dunn, RHIA, CPA, COO
June 5, 2008

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