AHIMA Distance Education

Understanding RAC Audit Trends

Audio Seminar / Webinar

November 4, 2008

Practical Tools for Seminar Learning

Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

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 of Contents

(CONTINUED)

Table of Contents

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**

1

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

2

Notes/Comments/Questions

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)**

3

Polling Question #2

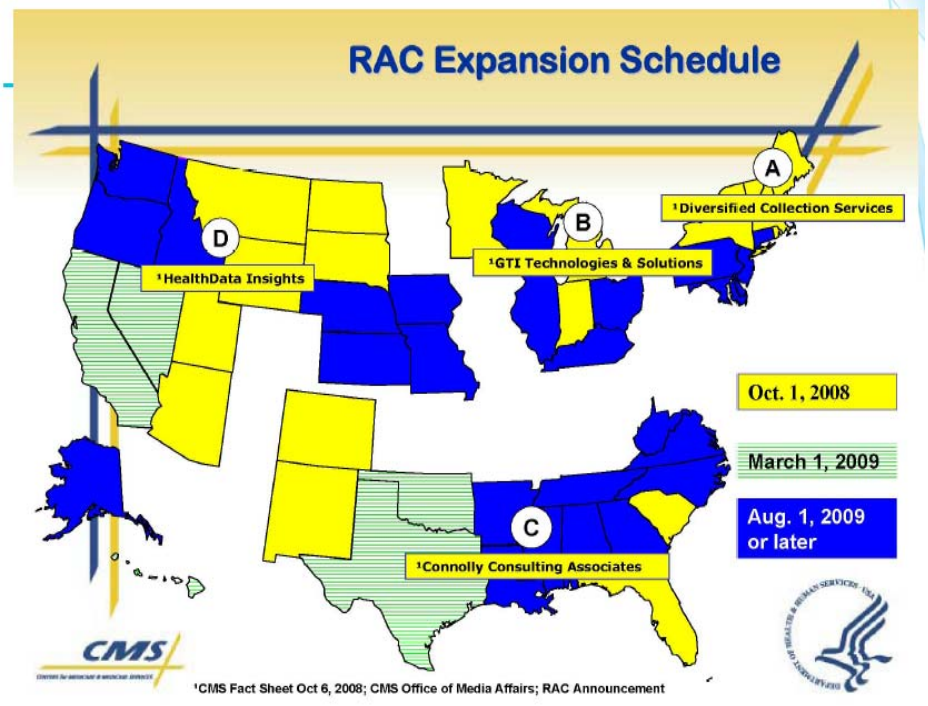
- **How much money does CMS spend annually on government funding, beneficiary premiums, and other resources for Medicare?**
  - * **1. 100 billion**
  - * **2. 200 billion**
  - * **3. 356 billion**
  - * **4. 456 billion**

4

RAC Legislation Background

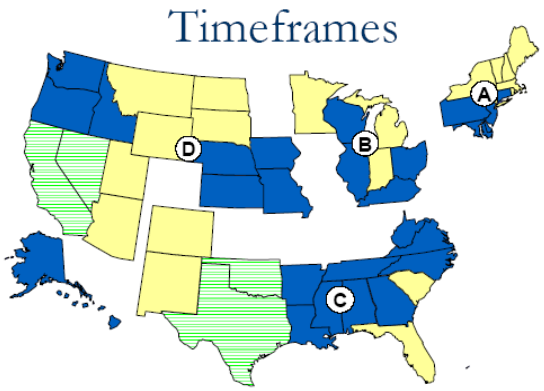
- **Medicare Modernization Act Section 306:**
  - **required RAC demonstration**
- **Tax Relief and Healthcare Act of 2006, Section 302:**
  - **requires permanent and nationwide RAC program by no later than 2010**
  - ***Both statutes gave CMS the authority to pay RACs on a contingency fee basis.**

5



6

RAC Timeframe



Claims Available for Analysis	Provider Outreach	Earliest Correspondence
Oct 15, 2008	Nov 2008	Dec 1, 2008
Jan 15, 2009	Feb 2009	Mar 1, 2009
Jun 15, 2009	Jul 2009	Aug 1, 2009

7

RAC Contacts

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

RAC	CMS Contact Person	Email Address
A DCS	Ebony Brandon	Ebony.Brandon@cms.hhs.gov
B CGI	Scott Wakefield	Scott.Wakefield@cms.hhs.gov
C CONNOLLY healthcare	Marie Casey	Marie.Casey@cms.hhs.gov
D HealthDataInsights	Marie Casey	Marie.Casey@cms.hhs.gov

7

Source: CMS RAC Call 10/08

8

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)

9

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)**

10

RAC Lessons Learned

	Demonstration RACs	Permanent RACs
Look back period (from claim pmt date – date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Discussion with RAC medical director regarding claim denials if requested	Not Required	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Vulnerability reporting	Limited	Mandatory
RAC must payback the contingency fee if the claim overturned at…	…first level of appeals	…all levels of Appeal
Web-based application that allows providers to customize address & contact	None	Mandatory by Jan. 1, 2010
External validation process	Not Required	Mandatory

11

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**

12

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.**

13

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.**

14

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**

15

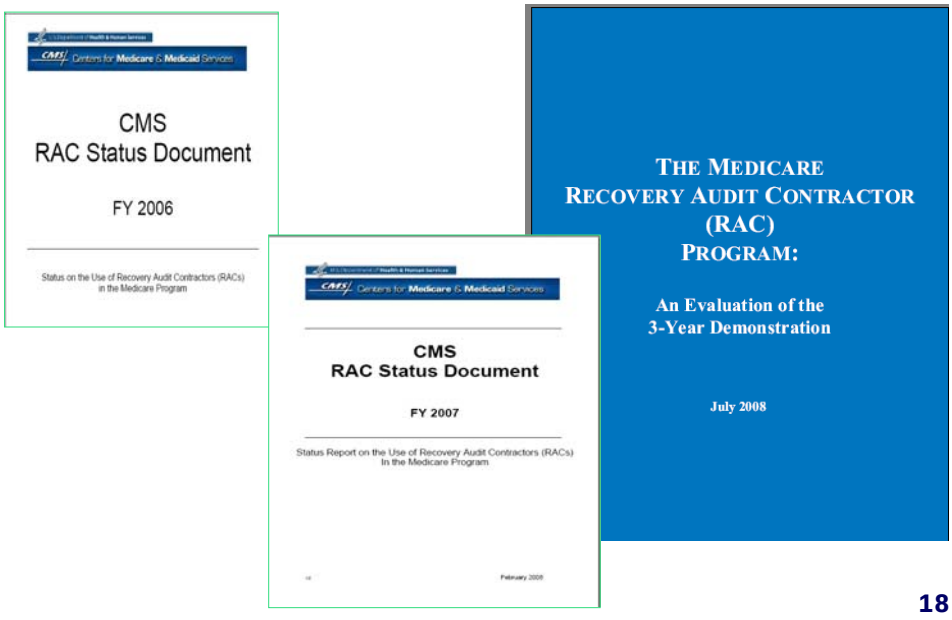
16

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**

17

CMS RAC Reports… (worth review)



18

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.**

19

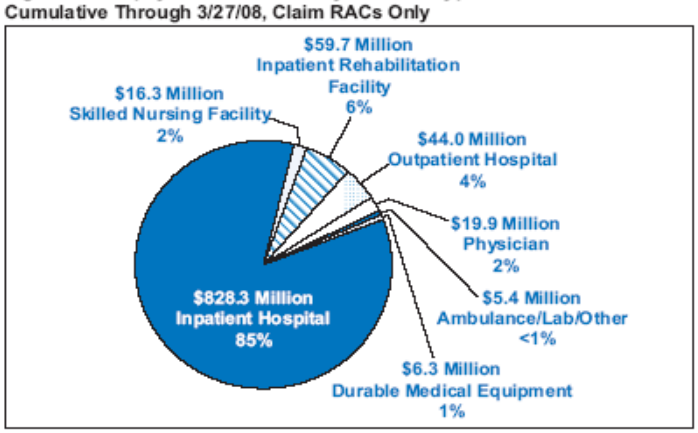
CMS RAC Status Report (7/08)

- **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.**

20

RAC Status Report

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



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

21

RAC Status Report

Appendix E
Overpayments Collected by Error Type and Provider Type

Table E1. Overpayments Collected by Error and Provider Type (Net of Appeals):
Cumulative Through 3/27/08, Claim RACs Only
(Percent of Total)

Error Type	Inpatient Hospital	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Outpatient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equipment	Total Overpayments Collected
Medically Unnecessary	34.50	5.63	0.26	0.47	0.00	0.00	0.00	40.86
Incorrectly Coded	30.48	0.00	0.62	2.44	1.05	0.06	0.00	34.66
No/Insufficient Documentation	6.63	0.44	0.48	0.11	0.00	0.00	0.09	7.76
Other	12.57	0.00	0.41	1.22	1.44	0.45	0.63	16.72
Total	84.19	6.07	1.76	4.25	2.50	0.51	0.72	100.00

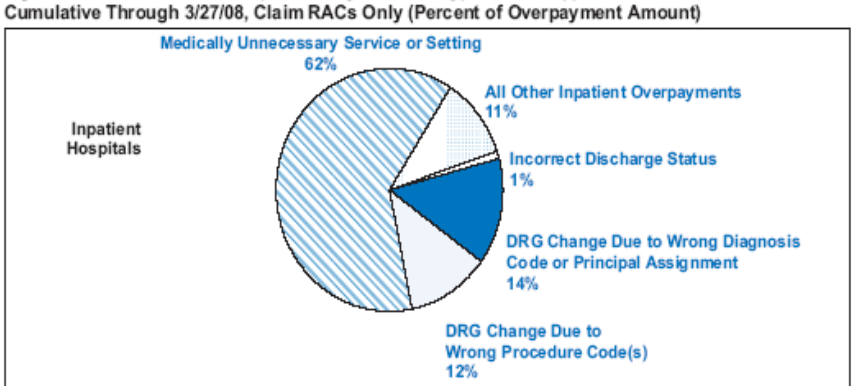
Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.

22

Hospital Specific Audit Findings/Trends

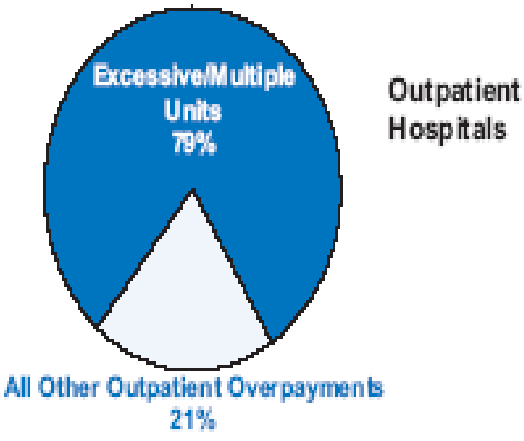
Appendix F
Audit Areas and Top Errors by Provider Type

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)



23

RAC Audit Findings/Trends



24

Notes/Comments/Questions

RAC Audit Findings/Trends

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

Claim Facts

- Principal diagnosis on claim did not match the principal diagnosis in the medical record.
- Example: respiratory failure (code 518.81) was listed as the principal diagnosis but the medical record indicates that sepsis (code 038-038.9) was the principal diagnosis.
- 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.
- Most common DRGs with this problem:
  - DRG 475 (respiratory system diagoses)
  - DRG 468 (extensive OR procedure unrelated to principal diagnosis)

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 billing for DRG 468 and 475.
- Providers and Medicare claims processing contractors can refer to the Federal Register: February 11, 1998 (Volume 63, Number 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also 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.

25

RAC Audit Findings/Trends

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

Claim Facts

- Hospital reported a principal diagnosis of 03.89 (septicemia)
- Medical record shows diagnosis of urosepsis, not septicemia or sepsis; Blood cultures were negative
- Did not meet the coding guidelines for "septicemia." Changing the diagnosis code to urinary tract infection (UTI) caused the claim to group to a lower DRG
- 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.

Corrective Actions

- Hospitals can be more careful when submitting claims for septicemia
- 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 28) for guidance on the proper coding of nondiagnostic preadmission services.
- Also refer also 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.

26

RAC DRG Audit Targets

- **Inpatient DRGs:**

High paying 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**

27

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.**

28

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.**

29

CHW RAC DRG Targets

B	C	D
CODING	**$**	**#**
475 RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR	[redacted]	67
415 O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEA		52
076 OTHER RESP SYSTEM O.R. PROCEDURES W CC		62
515 CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH		17
217 WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSK		63
468 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIP/		37
263 SKIN GRAFT & /OR DEBRID FOR SKN ULCER OR CELLU		73
120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES		38
535 CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI /HF /		11
416 SEPTICEMIA AGE >17		50
127 HEART FAILURE & SHOCK		32
148 MAJOR SMALL & LARGE BOWEL PROCEDURES W CC		23
124 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH		35
007 PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC		23
089 SIMPLE PNEUMONIA & PLEURISY W CC		24
	($6,223,115)	607

Highest $ impact at the top – DRG 475 and descending

30

CHW RAC DRG Targets: Inpatient Medical Necessity

B	C	D
MEDICAL NECESSITY	**$**	**#**
515 CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	[redacted]	33
127 HEART FAILURE & SHOCK		132
124 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH		74
115 PERMANENT PACEMAKER IMPLANT		25
315 OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES		32
089 SIMPLE PNEUMONIA & PLEURISY W CC		65
118 CARDIAC PACEMAKER DEVICE REPLACEMENT		36
088 CHRONIC OBSTRUCTIVE PULMONARY DISEASE		60
524 TRANSIENT ISCHEMIA		73
132 ATHEROSCLEROSIS W CC		82
294 DIABETES AGE >3 5		52
120 OTHER CIRCULATORY SYSTEM O.R. PROCEDURES		16
138 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W		55
116 OTHER PACEMAKER IMPLANT		16
139 CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/		74
	($6,074,631)	825

31

CHW RAC Targets: Rehab Medical Necessity

REHAB	$	#
462 REHABILITATION (includes nonDRG IRF)	($6,282,243)	464

Many were appealed and Significant reversals have now occured

32

CHW RAC Tracking – Statistics

	RAC (PRG SCHULTZ) IP CHART REQUESTS		
	(data covers activity since inception of program in November 2005)		
STATUS: September 24, 2008			
CHARTS REQUESTED	20221		
RAC RESPONSES			
CHANGE DETERMINATION	5215	25.8%	
NO FINDINGS	11586	57.3%	
PENDING/NO RESPONSE	3418	16.9%	
CHW RESPONSE TO CHANGE DETERMINATION			
ACCEPT	2327	44.6%	
APPEAL	2057	39.4%	
PENDING/NO RESPONSE	831	15.9%	
RAC RESPONSE TO APPEAL			
ACCEPT	181	8.8%	
DENY	609	29.6%	
PENDING/NO RESPONSE	1267	61.6%	
FI RESPONSE			
APPEAL SUCCESSFUL	158	15.8%	
APPEAL DENIED	839	84.2%	
QIO RESPONSE			
APPEAL SUCCESSFUL	102	43.2%	
APPEAL DENIED	134	56.8%	
ALJ RESPONSE*			
APPEAL SUCCESSFUL	227	98.3%	
APPEAL DENIED	4	1.7%	

Net Change	Charts	per chart		
Takebacks				
$ (34,147,269)	4672	$ (7,309)		
Payment Received				
$ 7,823,387	969	$ 8,074	NET	$ (26,323,882)

Net Change	Charts	per chart		
Takebacks				
$ (32,805,140)	4641	$ (7,069)		
Payment Received				
$ 7,029,414	893	$ 7,872	NET	$ (25,775,726)

33

CHW Hospital Specific RAC Findings

	A	B	C	D	E	F	G	H	I	J
1	**BREAKDOWN BY HOSPITAL**									
2										
3			Audit Type							
4	Hospital	Data	Coding	IP Rehab	MD Order	Med Nec	Other	Unspecified	Grand Total	
5	Hosp A	Take Back $	-$9,832						($9,832)	
6		Take Back #	8						8	
7		Payment Rec'd	$						$0	
8		Payment Rec'd	#						0	
9	Hosp B	Take Back $	-$75,909			-$441,223	-$18,628	-$18,628	($535,760)	
10		Take Back #	10			74	5	5	89	
11		Payment Rec'd	$			$33,437	$5,399	$5,399	$38,836	
12		Payment Rec'd	#			9	2	2	11	
13	Hosp C	Take Back $	-$1,266,899			-$223,714	-$27,016	-$27,016	($1,517,629)	
14		Take Back #	138			30	3	3	171	
15		Payment Rec'd	$181,574			$42,530			$224,104	
16		Payment Rec'd	41			7			48	
17	Hosp D	Take Back $	-$780,046			-$201,681	-$147,324	-$147,324	($1,129,051)	
18		Take Back #	103			33	19	19	155	
19		Payment Rec'd	$156,769						$156,769	
20		Payment Rec'd	26						26	
21	Hosp E	Take Back $	-$250,803	-$649,578	-$72,034	-$807,819			($1,780,235)	
22		Take Back #	38	48	10	132			228	
23		Payment Rec'd	$384,834	$171,064	$61,067	$475,657			$1,092,622	
24		Payment Rec'd	43	11	7	87			148	
25	Hosp F	Take Back $	-$19,877			-$8,522			($28,399)	
26		Take Back #	6			1			7	
27		Payment Rec'd	$						$0	
28		Payment Rec'd	#						0	

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 clinicans
      - May need to revise documentation forms

1st Qtr 2008 – new guidance from AHA… review

35

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**

36

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

37

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

38

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**

39

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**

40

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**

41

Polling Question #3

- **Has your Hospital, Health System or Practice developed a RAC assessment strategy?**

  ***1 Yes**

  ***2 No**

  ***3 Under discussion**

42

RAC Planning

43

Revenue Cycle Components

Pre-Encounter	Encounter	Post-Encounter
1. Scheduling	9. Clinical Care/ Documentation/ Transcription	17. Claims Preparation
2. Medical Necessity Determination	10. HIM	18. Claims Submission
3. Pre-Registration	11. Coding	19. Third Party Follow-Up
4. Registration and Demographic/ Insurance Validation	12. Charge Capture	20. Self-Pay Follow-Up
5. Insurance Verification	13. Charge Entry	21. Rejection Processing
6. Pre-Certification	14. Charge Description Master	22. Payment Posting
7. Financial Counseling	15. Billing Master	23. Payment Validation
8. Point of Service Collections	16. Case Management	24. Denial and Appeal Management
		25. Contracts
		26. Bad Debt Management

44

A Compliant Process

45

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**

46

Revenue Integrity Team

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

47

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

48

A Comprehensive Compliance Assessment Provides:

Review of:

- **Current Billing and Coding**
- **Policies and procedures**
- **Oversight responsibilities**
- **Employee training**
- **Monitoring and auditing**
- **Discipline and enforcement**

49

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**

50

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

51

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

52

RAC Preparation

53

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**

54

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**

55

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**

56

Proactive Approach – Just What the Doctor Ordered

- Data Analytics is 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

57

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 <u>all</u> documentation and communication

58

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**

59

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**

60

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**

61

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.**

62

Summary & Keys to Success

63

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**

64

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**

65

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**

66

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"?

67

Summary

Appendix R
Key Dates

Table R1. Key Dates

Activity	Date
Congress passes Section 306 of the Medicare Modernization Act requiring the use of RACs	December 2003
CMS announces RAC demonstration	January 2005
CMS releases Requests for Proposals (RFP) for NY, FL, and CA	January 2005
CMS signs contracts for Claim RACs in NY, FL, and CA and MSP RACs in FL and CA	March 28, 2005
RACs begin releasing significant overpayment notifications	January 2006
CMS signs contract for MSP RAC in NY	February 23, 2006
FY 2006 Status Document released	November 16, 2006
Congress passes Section 302 of the Health Care Act of 2006, which requires the RAC program be made permanent and implemented nationally by 2010	December 2006
CMS releases Request for Information and draft Statements of Work for 4 permanent RACs	March 16, 2007
CMS signs contract for demonstration Claim RACs to expand to MA, SC, and AZ	June 2007
RFP for RAC permanent program released	October 19, 2007
Proposals due from bidders wishing to become a permanent RAC	December 17, 2007
FY 2007 Status Document released	February 28, 2008
RAC demonstration ends	March 27, 2008
Release Demonstration Evaluation Report	June 2008 (anticipated)
Award national RAC contracts	TBD
Begin provider outreach in summer 2008 RAC States	TBD

68

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

http://www.cms.hhs.gov/RAC/Downloads/2008%20RAC%20Status%20Document%20vs1.pdf

www.cms.hhs.gov/RAC

kimberly.brandt@cms.hhs.gov

69

Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) – icon on top right
AHIMA Member ID number and password required – for members only

Join the **Coding Community**
from your Personal Page under Community Discussions,
choose the *Audio Seminar Forum*

You will be able to:

- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars

Visit our Web site
http://campus.AHIMA.org
for information on the
2008 seminar schedule.
While online, you can also register
for seminars or order CDs and
pre-recorded Webcasts of
past seminars.

AHIMA
Distance Education

Upcoming Seminars/Webinars

Facility Coding for ED Services
November 6, 2008

***Coding Clinic* Update**
November 20, 2008

2009 CPT Update
December 4, 2008

Thank you for joining us today!

Remember – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:

http://campus.ahima.org/audio/2008seminars.html

Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate

Certificates will be awarded for AHIMA Continuing Education Credit

Appendix

Appendix

Resource / Reference List

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

RACinfo@aha.org

http://www.cms.hhs.gov/RAC/Downloads/2008%20RAC%20Status%20Document%20vs1.pdf

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 and Abbreviations

- **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

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

AHIMA
Distance Education

To receive your

CE Certificate

Please go to the AHIMA Web site

http://campus.ahima.org/audio/2008seminars.html
click on the link to
"**Sign In and Complete Online Evaluation**"
listed for this seminar.

You will be automatically linked to the
CE certificate for this seminar after completing
the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.