Auditing Your RAC Results: What It Means for Your Organization

Audio Seminar/ Webinar
May 7, 2009
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**Sharon B. Easterling, MHA, RHIA, CCS**

Sharon B. Easterling is assistant vice president of the RAC department for Carolinas Medical Center in Charlotte, NC, where her responsibilities include overseeing the system-wide RAC audits, education, monitoring, and tracking. Ms. Easterling’s previous experience includes director of coding operations, HIM and coding director, as well as HIT program director. She also has experience working with physicians on documentation improvement.

**Donna Wilson, RHIA, CCS**

Donna Wilson is senior director of the consulting division of Compliance Concepts, Inc., where her primary focus is to assist providers in the RAC initiative. Ms. Wilson experienced the RAC demonstration project first-hand in her home state of South Carolina, gaining insight into the RAC process and how to better handle this additional burden placed on healthcare organizations. She has over 25 years of experience in coding quality and HIM.
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**Goals & Objectives**

- Review RAC History
- Learn how to identify types of errors commonly targeted during a RAC audit
- Review sample data from a RAC audit
- Analyze the financial impact according to type of error
- Illustrate how to conduct a cost benefit analysis of appealing the results of a RAC audit

**Why the RAC Initiative?**

- CMS designed the RAC Program to:
  - Detect and correct *past* improper payments in the Medicare program; and
  - Provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing *future* improper payments thereby lowering the payment error rate.
### Demonstration Findings

**March 2005 - March 2008**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overpayments Collected</td>
<td>$992.7 m</td>
</tr>
<tr>
<td>Less Underpayments Repaid</td>
<td>($37.8 m)</td>
</tr>
<tr>
<td>Less $ Overturned on Appeal</td>
<td>($46.0 m)</td>
</tr>
<tr>
<td>Less PRG IRF Re-review</td>
<td>($14.0 m)</td>
</tr>
<tr>
<td>Less Costs to Run Demo</td>
<td>($201.3 m)</td>
</tr>
<tr>
<td><strong>Back to Trust Funds</strong></td>
<td><strong>$693.6 m</strong></td>
</tr>
</tbody>
</table>

*From the inception through March 27, 2008, the RAC demonstration spent only 20 cents for each dollar collected.*

### Improper Payments Fell Into 3 Categories for Hospitals:

- **42%** - Incorrect coding
- **41%** - Medically unnecessary or insufficient documentation
- **17%** - Other (ex: duplicate services)

Who are the Permanent RACs?

- On October 7, 2008, CMS has announced the following contractors as the four permanent RACs:
  - Region A: Diversified Collection Services, Inc. initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York;
  - Region B: CGI Technologies and Solutions, Inc. initially working in Michigan, Indiana, and Minnesota;
  - Region C: Connolly Consulting Associates, Inc. initially working in South Carolina, Florida, Colorado and New Mexico; and
  - Region D: HealthDataInsights, Inc. initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.
Trends and Patterns

Become RAC Ready

- Determine the coding focus for your healthcare facility by reviewing the same sources that the RAC uses:
  - OIG Audits/Reports/Annual Work Plan
  - CERT Audits/Reports
  - PEPPER Reports
  - National and local coverage determinations
Learn from the Past

- Review RAC Status Document FY06 and FY07 for RAC findings under the demonstration program
- Review CMS Evaluation of Demonstration dated June 2008

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

- PEPPER is an electronic data report containing hospital-specific data for 13 target areas — specific Diagnosis Related Groups (DRGs) and discharges that have been identified as at high risk for payment errors.
Use PEPPER as a Monitoring Tool

- PEPPER defines outliers as findings that are at or above the statewide 75th percentile or at or below the statewide 10th percentile for a given target area.
- PEPPER cannot be used to identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts to help hospitals identify and prevent payment errors.

Sample Data from a RAC Audit
**RAC REVIEWS**

**Automated**
- Electronic claim review
  - Duplicate claims
  - Same patient
  - Same date of service
  - Duplicate payment
  - RAC withdrawal

**Complex**
- Manual review
  - Suspected error
  - Medical record needed
    - 45 days to reply
  - Site of service issue
  - Proper documentation

---

**RAC Denials**

**Common Denials**

- Denial Reason
- Duplicate Claim
- Excessive Units of Service
- No/Insuff. Documentation
- Incorrect Coding
- Discharge Diagnoses
- Medically Unnecessary
RAC DETERMINATIONS

- Each RAC will have their own letter format
- Data elements may vary between underpayments and overpayments
- Stamp the date the letter was received onto all RAC correspondence

DETERMINATION LETTER
(Claim Overpayment - HDI)

Data elements received in letter
(Part A claim):

- Provider Name
- Provider #
- Audit ID #
- Patient Name
- HI C #
- DOB
- Service From Date
- Service Thru Date
- Claim #
- Medical Record or Account #
- Audit message
- Benefits Paid
Case Scenario of an Overpayment Complex Review – Cardiac Patient

- **Presentation on Admission (POA):**
  - 66 Y Male to ER
  - c/o CP
  - Heart Catheterization recommended

- **Evaluation/Tx Period:**
  - L heart catheterization – uncomplicated
  - D/ C home w/ f/ u

Case Scenario of an Overpayment Complex Review – Cardiac Patient

- **Admission Denial:**
  - No inpatient acuity documented; no complication post procedure or acute intervention; should have been Outpatient Surgery.
DETERMINATION LETTER
(Claim Underpayment - Connolly)

Data elements received in letter
(Part B claim):

- Provider Name
- Provider #
- HI C #
- DOB
- Medical Record or Account #
- Begin DOS
- End DOS
- Billed charges
- Reimbursement charges
- Claim reason
- HCPCS code

Case Scenario of an
Underpayment Automated Review

- Units of Service on Part B claim:
  - The number of units billed for HCPCS code C9205 (Oxaliplatin: a chemotherapy drug for colorectal cancer) was billed incorrectly.
  - Health record indicates twenty-four (24) units documented; however, the provider only billed eight (8) units.
### DETERMINATION LETTER (No Recovery - Connolly)

Data elements received in letter *(Part A claim):*

- Provider Name
- Provider #
- HIC #
- Medical Record or Account #
- Begin DOS
- End DOS
- Total Charges
- Total reimbursement
- Scheduled payment date
- Auditor initials

### CLAIM STATUS REPORT FROM RAC

<table>
<thead>
<tr>
<th>Audit#:</th>
<th>Claim#:</th>
<th>MR#:</th>
<th>Pt. Name:</th>
<th>HIC#:</th>
<th>Status</th>
<th>Improper Payment</th>
<th>Reason for Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>123</td>
<td>456</td>
<td>789</td>
<td>Smith</td>
<td>45679</td>
<td>Overpayment</td>
<td>$5975.61</td>
<td>Inpt. Should have been billed as an Outpatient</td>
</tr>
<tr>
<td>890</td>
<td>990</td>
<td>778</td>
<td>Jones</td>
<td>99879</td>
<td>Underpayment</td>
<td>$70.79</td>
<td>Underpayment-Unit Count</td>
</tr>
<tr>
<td>556</td>
<td>667</td>
<td>889</td>
<td>Brown</td>
<td>00998</td>
<td>No findings</td>
<td>$0.00</td>
<td>Documentation supports services rendered</td>
</tr>
</tbody>
</table>
**RAC Denial Process**

- Same as for Carrier, FI and MAC identified overpayments (except the demand letter comes from the RAC)
- Carriers, FIs and MACs issue Remittance Advice
- Remark Code N432: “Adjustment Based on Recovery Audit”
- RAC issues a demand Letter
- Carrier/ FI / MAC recoup by offset unless provider has submitted a check or a valid appeal
**Agree with RAC Determination**

- Pay by check on or before Day 30 (interest is not assessed) and do not appeal
- Allow recoupment (Overpayment + interest) on Day 41 and do not appeal
- Request or apply for extended payment plan (Overpayment + interest) and do not appeal

**Disagree with RAC Determination**

- Pay by check on or before Day 30 (interest is not assessed) and file an appeal by Day 120
- Allow recoupment (Overpayment + interest) on Day 41 and file an appeal by Day 120
- Stop the recoupment by filing an appeal before Day 30
- Request or apply for extended payment plan (Overpayment + interest) and appeal by Day 120
Follow-up on RAC Determinations

- Monitor RAC determinations with facility compliance plan
- Self-disclose any improper payments
- Add compliance plan to RAC database
- Report quarterly to board and/or senior leadership

Example of Recoupment at Day 41

- Total Overpayment Amount: $1,000.00
- Rate of Interest: 11.00%
- Annualized Interest (1,000 X .11): $110.00
- Monthly Interest Amount (110/12): $9.17
- Total Interest Due (9.16 X 2): $18.34
**CMS Interest Rates**

- On April 9, CMS lowered the interest rate for Medicare overpayments and underpayments from 11.375% to 11.00%, effective April 16.
- Effective date: April 16, 2009
- Implementation date: April 16, 2009
- Transmittal 151 Date: April 9, 2009
- Change Request 6240

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**Appeal Your Denials**

![Appeal Your Denials Image]
If appeal within 30 days – NO Recoupment

Recoup 41st day

Financial Burden

- The AHA has estimated that it costs a provider an average of $2,000 to $7,000 to file a RAC appeal [sources: American Hospital Association and the Wellington Group]
- Interest rates approximate 11% annual rate
- Interest continues to accrue during the appeals process and until all monies are recouped
**Financial Burden**

**WHAT COST SHOULD YOU EXPECT?**

- The average 100 bed hospital should expect 50 medical record claims requests per month
- If only half of those are appealed to the ALJ level you should expect a cost of $300,000 annually in time and expense of the appeals
- During the pilots the average take back was $4,000 per claim. This means with the $300,000 in expense the hospital should expect another $300,000 in denials upheld at the ALJ level

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**Provider Appeals of RAC as of 8/31/08:**

- **Initiated Overpayments/ Claim RACs Only:**
  - # of claims w/ overpayment determinations = 525,133
  - # of claims where provider appealed (any level) = 118,051
  - # of claims w/ appeal decisions in provider’s favor = 40,115
  - Appealed claims w/ a decision in provider’s favor = 34

Source: RAC invoice files, RAC Data Warehouse, and data reported by the Administrative Qualified Independent Contractor (AdQIC) and Medicare claims processing contractors.
Appeal Checklist – Level I

- **Level I Appeal - Redetermination**
  - Cover Letter
  - Copy of RAC determination
  - Entire Health Record w/ marked pages to support documentation
  - Additional evidence documentation (AHA Coding Clinic, Interqual/ Milliman criteria set)
  - Appeal Letter

Appeal Checklist – Level II

- **Level II Appeal - Reconsideration**
  - Additional evidence documentation - *This is the last time to submit without having to show “good cause”*
  - Appeal Letter - *(Be sure to address any new items that may have surfaced from the redetermination Contractor’s denial notice)*
Appeal Checklist – Level III

- **Level III - Administrative Law Judge**
  - Appeal Letter or Legal Brief
    - Thorough record of circumstances surrounding the review and previous appeals (chronological record of events leading up to the request for ALJ hearing)
    - Include all clinical justification including specific references to the medical record documentation or additional evidence submitted
    - References to CMS Regulations, LCDs, NCDs, Screening Criteria, etc.
    - Any additional supportive legal arguments related to the case

Appeal – Plan of Action

- **PLAN OF ACTION**
  - Evaluate Key Factors
  - Develop a Decision Matrix
  - Perform Cost Benefit Analysis
  - Finalize initiatives
**Appeal - Key Factors**

- Deadlines
- Documentation
- Medical Necessity
- Clinical support
- Cost
- *Staff - Consultants - Outside legal counsel*

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**Decision Matrix**
**Decision Matrix**

<table>
<thead>
<tr>
<th>Medical Necessity</th>
<th>Case Management \ Medical Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft Coding</td>
<td>HIM Department</td>
</tr>
<tr>
<td>Hard Coding</td>
<td>Chargemaster/Department</td>
</tr>
</tbody>
</table>

**Decision Matrix**

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>HIM Department \ Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>HIM Department \ Documentation Specialist</td>
</tr>
<tr>
<td>ALL DENIALS</td>
<td>RAC TEAM AWARENESS</td>
</tr>
</tbody>
</table>
Auditing Your RAC Results:
What It Means for Your Organization

Appeals

* Ask Yourself
  - Is this a one time issue or most likely a recurrent problem?
  - Do you have support within the documentation including medical necessity?
  - Do we need outside counsel?
  - Is their guidance from Medicare?
  - Am I within the preset cost threshold?

Cost Benefit Analysis

Amount in Controversy must be at least:

- ALJ: $120
- Federal District Court: $1,220

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial cost of mailing to RAC</td>
<td>$108.00</td>
</tr>
<tr>
<td>20 cases @ 45 pgs ea. = 900 pgs</td>
<td></td>
</tr>
<tr>
<td>Salary of employees involved in RAC process</td>
<td>$70.00 internal</td>
</tr>
<tr>
<td>$160.00 external (prep, review)</td>
<td></td>
</tr>
<tr>
<td>Clerk $10, nurse $30 p/hr - consultant $75</td>
<td></td>
</tr>
<tr>
<td>Subsequent cost of mailing record/additional documentation</td>
<td>Varies</td>
</tr>
<tr>
<td>Cost of legal counsel</td>
<td>$100.00 internal</td>
</tr>
<tr>
<td>$150.00 internal</td>
<td>$100 p/hr - internal</td>
</tr>
<tr>
<td>$150-$300 p/hr - external</td>
<td></td>
</tr>
<tr>
<td>Appeal with legal counsel</td>
<td>$800.00 internal</td>
</tr>
<tr>
<td>$1,200.00 external (prep and hearing)</td>
<td>Prep - 5-8 hrs.</td>
</tr>
<tr>
<td>Hearing - 1-5 hrs - dependent on cases</td>
<td>Varies</td>
</tr>
<tr>
<td>Court fees</td>
<td>Varies</td>
</tr>
<tr>
<td>Federal District Court filing fees</td>
<td>$350.00</td>
</tr>
<tr>
<td>Amount in controversy</td>
<td>Varies</td>
</tr>
</tbody>
</table>
Prevent Future RAC Denials by Implementing Process Improvements

- Placement of Case Managers in the Emergency Department 7AM - 12AM to minimize patient status issues.
- One Day stays are monitored by Case Management and HIM.
- Utilize Bill Type 121 or Code 44 for cases that don’t meet Inpatient or Observation criteria.
- Implement a Ticket to the hospital approach to minimize exposure of incorrect patient status denials.
### Ticket to the Hospital

**Sheet – Initial Order Set**

<table>
<thead>
<tr>
<th>Patient Status Order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Status MUST BE INDICATED PRIOR TO BED ASSIGNMENT.</strong></td>
</tr>
<tr>
<td><strong>Ambulatory/Outpatient</strong></td>
</tr>
<tr>
<td>- Includes procedure for which neither inpatient admission nor outpatient observation is expected.</td>
</tr>
<tr>
<td>- Includes the hospital's normal recovery period associated with procedure regardless of the time of the procedure.</td>
</tr>
<tr>
<td>- Hospital stay pre-authorized or not.</td>
</tr>
<tr>
<td><strong>Observation</strong></td>
</tr>
<tr>
<td>- Does not meet inpatient criteria. Contact Utilization Review: 728-0000 (XYZ Hospital) or 123-123-123-123 (ABC Hospital) with questions.</td>
</tr>
<tr>
<td>- Admission to inpatient admission when more time is needed to evaluate a patient's condition, response to treatment, and/or to determine the need for inpatient admission.</td>
</tr>
<tr>
<td>- Patient has complications following and ambulatory/ outpatient procedure.</td>
</tr>
<tr>
<td><strong>Admit Inpatient</strong></td>
</tr>
<tr>
<td>- Meets inpatient criteria. Contact Utilization Review: 728-0000 (XYZ Hospital) or 123-123-123-123 (ABC Hospital) with questions.</td>
</tr>
<tr>
<td>- Procedure is listed as an inpatient procedure only (e.g., Endovascular Aneurysm Repair, Carotid Artery Bypass, Total Shoulder Replacement, Radical Neck dissection, Open Cholecystectomy).</td>
</tr>
<tr>
<td>- Admission to critical care.</td>
</tr>
</tbody>
</table>

**Physician Signature Date/Time:**

**Nursing Signature Date/Time:**

---

### Ticket to the Hospital

- **Must accompany each patient to the hospital.**
- **Fax with all pre-registration material.**
- **Necessary to prevent future RAC denials!**
Update Physician Orders

- Implement “ticket” to the hospital
- Review all physician order sets
  - Confiscate old order sets from:
    - Print shop
    - Nursing Units
    - Intranet
    - Physician Offices

Staffing/Budgetary Assessments

- Review your current staffing - do you have enough staff to handle the RAC requests?
- Work with your Release of Information (ROI) company to discuss the volume of RAC requests.
- Budget for increased supplies, staffing, resources, consultants, legal fees, etc.
Educate Applicable Staff on RAC Determinations:

- Board
- Senior Leadership
- Physicians
- Department Heads
- Case Managers
- Coders
- Billers
- Clinical Documentation Specialists

Alert Your Staff

- Length of stay
  - Short stay DRGs with long length of stay
    - Example: Sepsis with LOS less than 3 days - ALOS for sepsis is 5 days
- Debridements without 360 revenue
- Review of POA assignment
- High Dollar drugs - Top 20 chemotherapy
- Problem coding errors (respiratory failure, lung biopsy, combination codes)
- Changes to Medicare Inpatient Only List
### Monitoring Risk

<table>
<thead>
<tr>
<th>HIGH</th>
<th>MEDIUM</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>High probability of RAC risk</td>
<td>Moderate probability of RAC risk</td>
<td>Low - zero probability of RAC risk</td>
</tr>
<tr>
<td>Unclear orders</td>
<td>Unclear orders with medical necessity of services - criteria met</td>
<td>Clear order - medical necessity met</td>
</tr>
<tr>
<td>Does not meet medical necessity for IP stay</td>
<td>Meets some criteria for IP stay (i.e. SI not IS)</td>
<td>Meets all criteria for IP stay</td>
</tr>
<tr>
<td>Direct admits outpatient procedure without medical necessity</td>
<td>Admission following surgery of minor procedures</td>
<td>Urgent need for surgical intervention reflective of medical necessity</td>
</tr>
<tr>
<td>Admission order written prior to procedure for other than inpatient only procedure without medical necessity</td>
<td>Extended recovery needed with clinical support documented - in IP status</td>
<td>Progression of patient from different levels of care noted and documented with medical necessity</td>
</tr>
</tbody>
</table>

### Monitoring Risk

<table>
<thead>
<tr>
<th>HIGH</th>
<th>MEDIUM</th>
<th>LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>High probability of RAC risk</td>
<td>Moderate probability of RAC risk</td>
<td>Low - zero probability of RAC risk</td>
</tr>
<tr>
<td>Incorrect DRG/APC Assignment - resulting in increased DRG/APC payment</td>
<td>DRGs in the RED zone on PEPPER Report</td>
<td>DRGs contained in OIG workplans with incorrect DRG assignment resulting in increased DRG payment</td>
</tr>
<tr>
<td>Correct DRG assignment</td>
<td>DRGs within acceptable range on PEPPER Report</td>
<td>Correct DRG assignment</td>
</tr>
<tr>
<td>MS-DRGs with one CC or MCC</td>
<td>Assignment of diagnosis as POA not reflected by documentation</td>
<td>Assignment of POA diagnosis reflected within documentation</td>
</tr>
</tbody>
</table>
Monitoring Risk

- Review of MSDRG 870 Septicemia or Severe Sepsis with mech vent greater than 96 hrs., wt. 5.7258
  - Review of 50 charts reveals 10 in error resulting in 20% risk rate
  - Total sepsis cases equal 200
  - Payment for DRG equals *(can use actual paid data)*
    - $1000 \times 5.725 = $5725
    - $5275 \times 200 \text{ cases} = 1,055,000
  - Risk equals 20% of 1,055,000 = $211,000

Monitoring Risk

- Review of data mined sample of One-Day Stays based on GI diagnosis
  - Review of 50 charts reveals 40 in error resulting in 80% risk rate
  - Total cases equal 200
  - Average DRG Payment for sample equals *(can use actual paid data)*
    - $1,500,000
  - Risk equals 80% of 1,500,000
    - $1,200,000
### Tracking

**Tracking**

#### Attending Physician Report

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physician Name</th>
<th>DRG</th>
<th>Charges</th>
<th>Length of Stay</th>
<th>Procedure Code</th>
<th>Diagnosis Code</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>Surgeon Brown</td>
<td>775</td>
<td>$12,000</td>
<td>7 days</td>
<td>2345</td>
<td>6789</td>
<td>Open</td>
</tr>
<tr>
<td>Hospital B</td>
<td>Doctor Davis</td>
<td>775</td>
<td>$13,000</td>
<td>8 days</td>
<td>2345</td>
<td>6789</td>
<td>Closed</td>
</tr>
<tr>
<td>Hospital C</td>
<td>Surgeon Green</td>
<td>776</td>
<td>$14,000</td>
<td>9 days</td>
<td>2345</td>
<td>6789</td>
<td>Open</td>
</tr>
</tbody>
</table>

**Tracking**

#### Recovery E-Trak

**Dashboard**

- Open Cases: 6
- Closed Cases: 3
- Completed: 7
- Appeals: 5
- Correspondence: 0
- Data Entry: 3
- Medical Records: 2

**Statistical Data**

- **Open Cases**: 6
  - Number of Cases: 6
  - Potential Recoupment: $12,000
  - Actual Recoupment: $10,000

- **Closed Cases**: 3
  - Number of Cases: 3
  - Potential Recoupment: $13,000
  - Actual Recoupment: $12,000

- **Applicants**: 5
  - Pending Appeals: 5
  - Level 1 Appeals: 3
  - Level 2 Appeals: 2
  - Level 3 Appeals: 1
  - Level 4 Appeals: 3
  - Level 5 Appeals: 2
IN THE MEAN TIME...

THERE IS WORK TO BE DONE!!!

IMMEDIATE ACTION REQUIRED!!!

- Interdisciplinary Team
- Standard Appeal Templates
- Formalize a Decision Matrix
  - Do you want one decision on costly appeals???
- Solidify your health records release process
- Know your risk and reduce it
IMMEDIATE ACTION REQUIRED!!!

- Determine RAC coordinators for all areas - not just your hospital
- Analyze your needs and fill the gaps
- Educate, educate, educate
  - Partner with your hospital associations, state and national HIM associations to provide and obtain education

Resource/Reference List

- Recovery Audit Contractor
  http://www.cms.hhs.gov/RAC/
Resource/Reference List

- Medicare Appeals Process
- Contractor Learning Resources
- Pub 100-04 Medicare Claims Processing

Cited Sources:

Stephen Forney, MBA, CPA, FACHE, FHFMA  
VP - Margin Development  
Ardent Health Services  
Nashville, TN  

Bill Phillips, FACMC, CHC  
Associate Professor  
Health Services Mgt.  
Geo Washington Univ. &  
VP & Chief Revenue Off  
Revenue Strategies
**Cited Sources**

Diane Paschal - SC Hospital Association
Corporate Compliance Director;
Bonnie Boehlke, RN-Director, Case Management; and
Bart Haas, MBA, RHIA - Director, HIM/ Patient Access, Conway Medical Center

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Appendix

Resource/Reference List ........................................................................................................... 38

CE Certificate Instructions
Resource/Reference List

http://www.cms.hhs.gov/RAC/
To receive your

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