



lead story

RACs Coming to a Provider near YOU!

By Laura Pait, RHIA, CCS,
Senior Manager



The RAC program's mission is to reduce Medicare improper payments through efficient detection and collection of overpayment, the identification of underpayments, and the implementation of actions that will prevent future improper payments.

Introduction

CMS initiated a pilot Recovery Audit Contractors (RACs) program in 2005. The initial states that were selected for this pilot were California, New York and Florida. These states were selected primarily because they are the largest states in terms of Medicare utilization. Approximately 25% of Medicare payments made each year is to providers in these states. The mission of the RACs is "To reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments."

Table 1-1
Names of Claim RACs and Jurisdictions

Original Groups in Demonstration Project.

Name of RAC	Jurisdiction (start date)
Conolly Consulting (New York)	New York (March 2005) Massachusetts (July 2007)
Health Data Insights (Florida)	Florida (March 2005) South Carolina (July 2007)
PRG-Schultz (California)	California (March 2005) Arizona* (July 2007)

Section 306 of the Medicare Modernization Act directed CMS to investigate Medicare claims payment using RACs to identify underpayments and overpayments and to collect the overpayments so that they may be returned to the Medicare Trust Fund. For Fiscal Year 2006 RACs identified \$289.1 million in overpayments but only \$10.4 million in underpayments. Recently published RAC summary documents have revealed overpayments collected for medically unnecessary services in an Inpatient Hospital or Skilled Nursing Facility in FY 2007 at \$106.5 million. Congress gave CMS the authority under the RAC demonstration legislation to pay the RACs differently. CMS pays each RAC on a contingency fee basis. It has been identified that RACs get to keep 20-30% of the dollar amount. This demonstration is the first time the Medicare program has ever paid a contractor on a contingency fee basis for a claim review and overpayment collection work.

FY2007 Overpayments vs. Underpayments

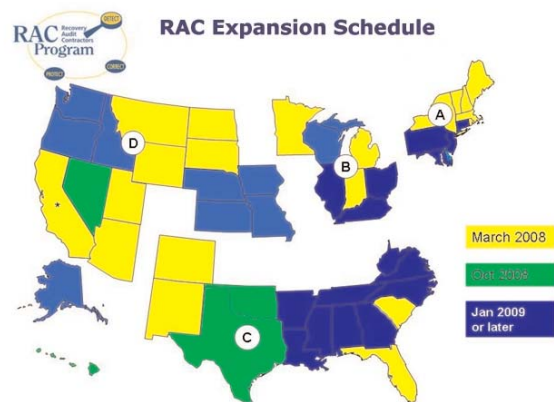
	Overpayments Collected		Underpayments Repaid		Total Improper Payments
Conl	\$112.5 m	+	\$ 1.8 m	=	\$114.3 m
HDI	\$124.6 m	+	\$4.1 m	=	\$128.7 m
PRG	\$120.1 m	+	\$8.4 m	=	\$128.5 m
Total	\$357.2 m	+	\$14.3 m	=	\$371.5 m

SOURCE: RAC Data Warehouse

Dangers Ahead

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. By 2010, CMS plans to have 4 RACs in place. The new RAC jurisdictions match the DME MAC jurisdictions. On March 16, 2007, CMS drafted a "statement of work" that provides details about the program, but more importantly outlines the suggested expansion of the program. Recent expansion of the program brought participation to South Carolina, Massachusetts, and Arizona. States targeted for program expansion in 2008 include Texas, New Mexico, and Oklahoma. States targeted for expansion in CY 2009 include West Virginia, Virginia, North Carolina, Tennessee, Georgia, and Alabama.

RAC Expansion Schedules



*California claims will not be available for review from March 2008-approximately Oct. 2008 due to a MAC transition



Areas that pose a danger for most providers include:

■ Request for Medical Records

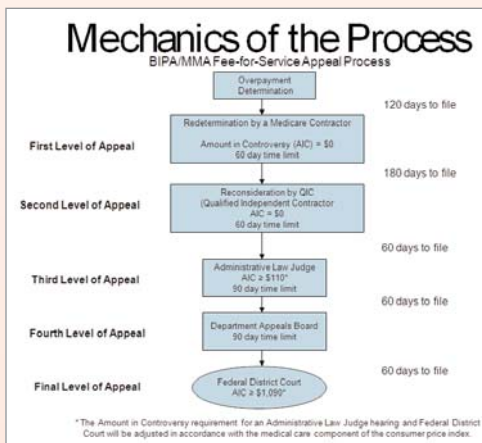
The RAC may obtain records by on-site visit and mail/fax. Providers today have not established procedures for handling these requests. Depending on the amount of records the RAC has requested to review, this could be a huge operational issue. To date, most providers are receiving requests for medical records and not an on-site visit. Depending on the size of the facility, some report lists of 100 patients while some report lists of just 15. The key is to be able to locate and send the copies within 45 days from the date the letter was issued, not from the date you received the request. If the RAC does not receive the records within the time frame specified it is an automatic denial. Providers today do not demonstrate a process that can track the request upon entry into their organization, if the request was complied with, and if the RAC received the records. It has been reported that the RACs are reporting they never received records and the provider can not prove they were sent. Homework that each provider can do is to verify with their FI/Carrier what address and contact person they have on file. Addresses change and we do have turn-over from time to time.

■ Appeal Process

Providers are overwhelmed with the detail required in the appeal process. CMS suspects that there are simply more overpayments made by the Medicare program due to lack of medical necessity and incorrect coding of claims than there are overpayments due to Medicare being the secondary payer. Lack of medical necessity and incorrect coding for Hospital and Physician outpatient claims is not new and although this remains part of the "automated" claim review, the inpatient complex review process has significantly challenged providers.

Providers are experiencing a great deal of confusion and lack of expertise when dealing with appeals related to Hospital inpatient services denied for lack of medical necessity relate to the inpatient admission. Providers are reporting the need to establish new positions within their organization just to address these concerns.

Providers must establish a clear appeals process. Ownership and accountability must be defined for the internal RAC program. Unfortunately, the RAC provides time restraints on the appeals process as well. If the appeal is not received within the defined time restraints, the denial will stand. Providers must not accept the denial on face value, but research and be sure you are in agreement with the interpretation of the LCDs, NCDs, coding guidelines and InterQual criteria. A 30% overturn rate has been reported on physician claim denials due to effective appeal preparation.

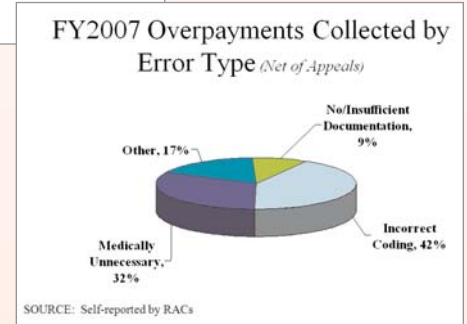
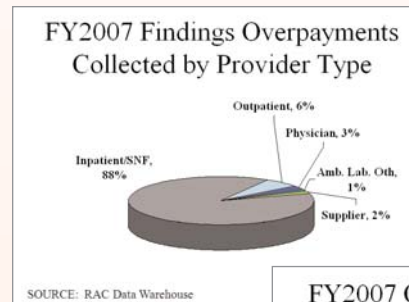


What is this talk about "Medical Necessity" for Inpatient Services?

Speaking with board members, senior leadership and Hospital staff this spring resulted in a common question What is this talk about medical necessity for inpatient services?

Financial case management has become a necessary part of every healthcare organization. What will the payer cover for an admission under 30 days? Was a procedure included that the payer will only cover as an outpatient? These are all questions that case managers address every day to help Hospitals ensure that they can bill for the services provided and they will be paid by the payer. So, how can we fit a "clinical" review of medical necessity in all of this?

Facilities that have elected to participate in the Medicare program have agreed to follow the "Conditions of Participation." Specifically 42 CFR Section 482.30 which details the required elements for a Utilization Review (UR) plan. This section notes that the Hospital's UR plan must review medical necessity of admissions, length of stay and services rendered. This review process is NOT THE SAME as the quality assessment and performance improvement reviews required under 42 CFR Section 482.21.



These RAC results demonstrate the application of review criteria in the judgment of medical need for the initial admission in particular for one-day stays during the "complex" review process that does include review of the medical record. To date we have not seen outcomes reflecting continued stay reviews.

When we reflect on the current UR process in Hospitals today, what do we see?

- UR absorbed into case management responsibilities
- Overwhelmed with the steps required to get approval of days for commercial payers
- No pre-admission reviews



■ Enormous work around or meetings to ensure physician satisfaction

Over time hospitals have seen this function fall to the side. Hospitals are continually challenged with the time involved in review of each medical record and the frequent need to speak with physicians. The other major influencing factor has been the apprehension and reluctance from Hospital leadership when questioning medical staff on the appropriateness of the care plan for this particular level of care.

It is now time to buckle down and address ALL the issues that need to be covered. What can you do?

- Dust off your current UR plan and be sure staff are aware of the steps involved
- Prepare Hospital leadership to help inform the medical staff of these issues
- Reinforce “what is in it for them” understanding with your medical staff

If your organization is talking about medical necessity of inpatient services, embrace this as your opportunity to make things right. Ensure your compliance with the Conditions of Participation with a risk assessment. Visit your recent coding reviews to see if medical necessity was addressed. Define corrective action, revisit staffing and be sure education and training is provided more than once.

As we prepare for RAC review, “Best” practice at any organization will require establishing a clear internal process. An effective UR plan provides a definition of ownership and accountability, but also requires awareness and support from Hospital leadership.

Recent Updates

October 19, 2007, a Request for Proposal (RFP) was issued by CMS seeking application for a national implementation. October 26, 2007, the American Hospital Association (AHA) issued a letter to CMS expressing concerns with the program and asking reconsideration of several key issues. November 7, 2007, a bill was introduced to place a moratorium on the RAC program. The bill directs CMS to provide Congress a detailed program status. California has expressed particular concern with the RAC process associated with inpatient rehabilitation claims.

The new statement of work notes the new four permanent RACs will be announced the first of 2008 and in early 2008, they will begin issuing letters to providers for medical records.

www.cms.hhs.gov/RAC

Get Prepared NOW!

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

Top 12 RAC Issues to Watch For

1. Debridement – procedure code on claim did not match procedure described in medical record
2. Respiratory Failure – principle diagnosis on claim did not match the principle diagnosis in the medical record
3. Discharge status/transfer – claim indicates discharge to home or other facility, but medical record indicates beneficiary was discharged to another hospital or home with home care
4. Inpatient Rehabilitation – services were medically necessary but could have been provided in a less acute setting
5. Neulasta – wrong number of unites billed
6. Speech Therapy – wrong number of unites billed for initial evaluation
7. Admission for scheduled elective procedures
8. Claims with single secondary diagnosis designated as a complication or comorbidity
9. Medical necessity for short stay admission, including chest pain, back pain, congestive heart failure, and gastroenteritis
10. Inpatient only procedures – know what changes from year to year
11. Transfusion – billing more than once per encounter
12. DRG payment window – outpatient procedures

Laura Pait, RHIA, CCS – Senior Manager, Revenue Integrity Solutions, Dixon Hughes PLLC Healthcare Consulting Group. Active membership with AHIMA and HFMA.

Demonstration vs. Permanent RACs

Strategy	Demonstration RACs	Permanent RACs
RAC Medical Director	Not Required	Mandatory
Coding Experts	Optional	Mandatory
Under Tolerance Threshold	\$10.00 aggregate claims	\$10.00 minimal claims
AC Validation Process	Optional	Mandatory
RAC must payback the contingency fee if the claim overturned at any level of Appeal	RAC must payback contingency fee if the claim is overturned on the first level of appeal	RAC must payback if the claim is overturned on any level of Appeal
Standardized Letters to Providers	Limited	Mandatory
Claims Reviewed	Records from three prior fiscal years	Claims with initial determination on or after October 1, 2007
Number of Records Requested	No limit per SOW	To be set by CMS