

When RAC is Back, Will Hospitals Be Ready?

A program the size of Medicare, with a network of contractors that process over 1.2 billion claims each year, submitted by more than 1 million health care providers, will never be free from errors. But in a system this large, where improper payments totaled an estimated \$10.8 billion in 2007¹, process improvements can make a significant difference. The Recovery Audit Contractor (RAC) demonstration project started in 2005, and identified more than \$1 billion in overpayments under Part A or B as of March 27, 2008, returning hundreds of millions of dollars to the Medicare Trust Funds.

The demonstration project ended in March 2008, but its results spurred Congress to make the program permanent and require the Centers for Medicare and Medicaid Services (CMS) to perform RAC reviews in all 50 states. CMS will launch RAC review nationwide by January 2010. The majority of overpayments recovered in the demonstration project – 85 percent of collections – came from inpatient hospitals, which now have a brief but valuable window to prepare for the inevitable arrival of letters requesting medical records for review.

“Smart hospitals are taking proactive steps to find their coding, documentation and billing process issues before a RAC does,” said Laurie Johnson, senior HIM consultant at Ingenix Consulting. “If you know your weaknesses, you can voluntarily self-report any cases with discrepancies, and a RAC cannot recover on the claims involved for the same issue that was self-disclosed. You can also fix the root cause of the errors and minimize your future exposure.”

Looking back, ahead and within

Under the permanent program, RACs will review records for improper payments on claims for the same general reasons as in the demonstration project:

- Services did not meeting Medicare’s medical necessity criteria
- Services were incorrectly coded

- Documentation was not submitted on request, or was insufficient to support a claim
- Claim payments were based on outdated fees schedules
- Duplicate claims were submitted, including inappropriately billed service units

Hospital teams can gain valuable insights from reviewing the demonstration project cases based on medical necessity and incorrect coding to identify likely RAC targets in the future. Also, thanks to a change in the look-back period under the permanent program, hospitals can focus their attention on analyzing claims paid on or after October 1, 2007, and within a rolling three-year window going forward.

Data mining and self-reporting issues may be the simplest step. Reducing ongoing errors and recoveries requires a committed, multidisciplinary team prepared to track RAC case trends and apply this knowledge across the facility. “Most hospitals already strive for correct payment, but now there is additional incentive to initiate a RAC-informed documentation improvement program or issue specific guidelines on correct coding,” observed Johnson. “Continuous, targeted education is required, possibly across hundreds or thousands of people in sizable facilities or systems.”

Rapid action on identified areas of improvement could pay off. In the demonstration project, RACs could not review claims in the current fiscal year. This limitation has been eliminated.

Johnson noted that hospitals will have access to increased and timelier information under the permanent program. By January 2010, all RACs must offer a Web-based application that enables providers to view the status of cases and update contact information. Also, CMS has stated that all new issues a RAC wishes to pursue for overpayments will be posted online for the benefit of provider organizations. In addition, if providers request a discussion with the RAC medical director regarding claim denials, this exchange will no longer be optional, but mandatory.

For hospitals new to the RAC experience, Johnson recommends reviewing and building on existing Medicare appeal processes and templates, and shaping a RAC-specific appeals strategy. She pointed out that according to CMS demonstration program statistics, those providers who felt confident enough to appeal RAC decisions – approximately 14 percent – succeeded in having them overturned only one-third of the time. Further, according to Johnson, “Under the permanent program, RACs will be more motivated to win appeals. Under the demonstration program, they only forfeited their contingency fee if they lost the first round of appeal. Now their fee will be lost if the appeal is successful at any level, up to final determination.”

Last but not least, Johnson believes hospitals should prioritize RAC-based risk reduction efforts in their high-volume areas. “Examine your specialties first for the greatest return on your investment,” she advised. “While RACs may not target claims solely because they’re high dollar, common sense dictates that they will scrutinize a facility’s highest-incidence services to maximize recovery.”

Reviewing systems investments and optimizing processes

Whether a hospital is new to RAC or seeking to mitigate past exposure as the permanent program takes effect, help is available. Coding support is a prime area for reassessment and optimization, as the leading coding and claims editing tools support code quality and identify compliance issues before claims are submitted. According to Johnson, the complex coding landscape is due to become even more challenging soon with changes to be implemented in October. “Coders must be prepared for the new concept of whether certain conditions were ‘present upon admission,’ with implications for DRG (diagnostic related group) payment by CMS,” she stated.

In addition to revisiting coding systems and skills, Johnson would remind hospitals of the need for up-to-

the-minute maintenance and periodic scrutiny of their chargemaster. She offered the example of an Ingenix Consulting client that her team assisted in identifying an incorrect medication code in their chargemaster.

“Coded properly, that medication is not separately reimbursed, but it was being charged with a HCPCS code that was reimbursed at \$106 per vial. We identified 200 instances of this mistake, and they will proactively pay back over \$20,000. But this error and others have been fixed at the source and the facility’s exposure minimized for the future.”

Johnson’s team also conducts mock RAC audits, pulling claims, applying proprietary criteria to the records and evaluating documentation. Such trial runs not only help identify variances for proactive correction, but can help hospitals evaluate support systems and skills, identify educational needs, fine-tune response procedures and ensure that their staffs are clear on RAC-related roles and responsibilities

With the launch of the permanent program, Johnson and her colleagues will once again be busy with “shadow audits,” or partnering with clients to examine the same records requested by a RAC. “Ingenix can look at those same claims with equal or greater expertise to identify any prospective issues and assess the available documentation,” she said. “We can help inform the decision of whether or not to appeal, and how to structure an appeal for the best chances of a favorable decision.”

The final word in RAC preparedness for any hospital is, according to Johnson, “education, education and more education. Identify your vulnerabilities and deal with the source of the decisions to provide services that didn’t meet medical necessity criteria. Close those gaps in awareness about correct code, and fix the processes that result in insufficient documentation.” She believes that the sum of eliminated risks offers more value than the individual parts. “As a contingency-fee operation, RACs will follow the money. You can help make sure that, going forward, your facility isn’t worth their time.”

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Endnotes

¹ From a January 2008 report by the Office of Management and Budget, cited in “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, June 2008”.