

North Carolina Association  
for Healthcare Quality  
Healthcare Professionals Collaborate  
to Enhancing the Health of Care.

## RAC Ready? Cause here we GO!

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## Faculty Disclosure

This presentation is designed to provide accurate and authoritative information in regard to the subject matter covered. The information includes both reporting and interpretation of materials in various publications, as well as interpretation of policies of various organizations. This information is subject to individual interpretation and to changes over time.

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## RAC Opportunity???



- The RAC Program makes available to us the opportunity to expand our policy manuals to include assessments, education, staff training, and process improvements.

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## RAC - Protest Resolved

- On February 4, 2009 the parties involved in the protest of the award of the Recovery Audit Contractor (RAC) contracts settled the protests. The settlement means that the stop work order has been lifted and CMS will now continue with the implementation of the RAC program.
- Under the program, the four RACs will contract with subcontractors to supplement their efforts. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C. Each subcontractor has negotiated different responsibilities in each region, including some claim review.

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## Mechanics of the Process

### Steps in the Process



```

graph TD
    A[Initial Communication] --> B[Receive Requests]
    B --> C[Respond to Requests]
    C --> D[Notification of Outcome]
    D --> E[Appeal Processes]
  
```



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## The Compliance Process

### Operational Implications

- Record requests up to 200 in a 45-day period for both inpatient and outpatient claims combined.
- Medical records must be copied and sent to RAC within 45 days of receipt of request (or technical denials occur)
- Most hospitals have not increased head counts to handle burden.

## Mechanics of the Process

### Responding to a RAC Record Request

- Providers must respond to request for records within 45 days
- Providers may request an extension at any time prior to the 45<sup>th</sup> day by contacting the RAC

### Appealing Denials

- Standard CMS appeal processing timelines
- First level inpatient (IP) appeals handled through FI rather than QIC
- All non-IP services handled through standard processes

## Revenue Integrity Team

- Corporate Compliance – co-chair with HIM Director
- Health Information Management
- Case Management
- Finance/Revenue Management
- CDM
- Billing
- Medical Staff
- Clinical Departments



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## OIG's Compliance Program Guidance for Hospitals

- One Size Does Not Fit All
- Program Must Not Be Stagnant  
 “Programs hastily constructed and implemented without appropriate ongoing monitoring will likely be ineffective and could result in greater harm or liability to the hospital than no program at all.” 63 Fed. Reg. 8988 (1998)

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## A Comprehensive Compliance Assessment Provides review of:

- Current Billing and Coding
- Policies and Procedures
- Employee Training
- Monitoring and Auditing
- Discipline and Enforcement
- Oversight Responsibilities

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## Compliance Solutions

An effective compliance program includes all the applicable elements.

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## Compliance Solutions

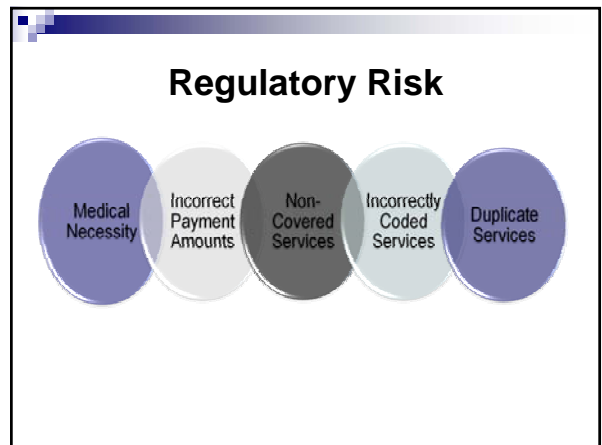
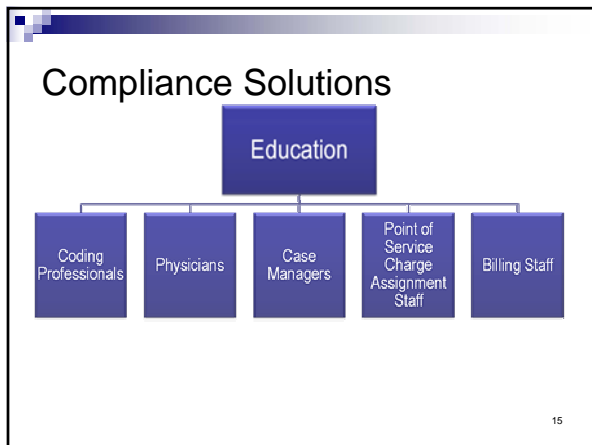
- Defend your data
- Review RAC overpayment determinations to confirm that the reason for overpayment is valid and the amount of alleged overpayment is substantiated
- Develop internal "appeal" guidelines
- Identify revenue opportunities in RAC designated underpayments
- Data mine and conduct pre-emptive assessments

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ICD9	Description	National Total Discharges	National % One Day Stay	Anywhere Hospital Total Discharges	Anywhere Hospital Total One Day Stays	Anywhere Hospital % One Day Stay
143	Chest Pain	194,888	45%	137	48	38%
329	Transient Ischemia	98,894	21%	53	14	25%
125	Cerebrovascular Disorders Except AMI w/ Card Cath w/o Complex Diag	74,359	24%	38	3	8%
183	Esophagitis, GERD/acid & Misc Digest Disorders Age >17 w/o CC	66,120	26%	17	3	18%
139	Cardiac Arrhythmia & Conduction Disorders w/o CC	61,327	24%	19	6	32%
132	Atherosclerosis w/o CC	61,081	29%	22	6	27%
248	Fluorine & Toxic Effects of Drugs Age >17 w/o CC	49,911	26%	31	6	19%
142	Syncope & Collapse w/o CC	38,710	33%	17	6	35%
268	Dysrhythmia	37,389	27%	17	2	12%
234	Hypertension	55,158	26%	35	6	19%
237	Functional & Misc Metabolic Disorders Age >17 w/o CC	34,753	22%	16	6	32%
247	Signs & Symptoms of Musculoskeletal System & Soft Tissue	19,840	23%	8	1	13%
239	Respiratory Signs & Symptoms w/o CC	19,089	27%	16	4	27%
883	Seizure Age >17 w/o CC	18,642	21%	7	1	14%
139	Urinary Infection w/o CC & w/ Exam Laboratory	15,819	39%	6	3	50%
254	Headaches Age >17	14,220	23%	8	1	12%
110	Angina Pectoris	13,964	26%	9	2	22%
249	Altercane, Musculoskeletal System & Connective Tissue	12,327	23%	2	0	0%
420	Acute Adjustment Reaction & Psychosocial Dysfunction	11,124	23%	1	0	0%
139	Chest Digestive System Diagnosis Age >17 w/o CC	10,838	20%	4	3	50%
194	Signs & Symptoms w/o CC	10,154	24%	6	1	20%

**Selected Medical Diagnoses - One Day Length of Stay Report**

Note: Hospital specific percentages are shown rather than volume in order to comply with confidentiality requirements for cell size. High percentages (such as 100%) may also result from a low volume.  
Data Source: 2007 Medicare claim data (Oct 2006 - Sep 2007)  
Excludes: Transfers to Another Acute Care Facility, Left Against Medical Advice, & Deaths  
US Data Excludes: Maryland, Puerto Rico, Virgin Islands

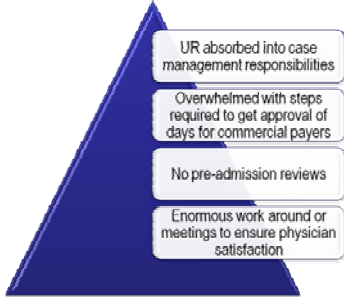


## Create Legitimate Opportunities

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## Regulatory Risk – Medical Necessity

## What do we see today?



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## Impact on Admissions/Registration

### Appropriate medical necessity screening...

- ...which Medicare defines as services or items reasonable and necessary for the diagnosis or treatment of illness or injury
- A provider who bills Medicare for services that Medicare deems not medically necessary can be prosecuted for fraud.
- Use scripts for Medicare compliance and documenting medical necessity.

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## Regulatory Risk – Incorrectly Coded Services

### Internal Data Mining

- High Risk DRGs
- High Volume DRGs
- High Cost
- High Volume OP services

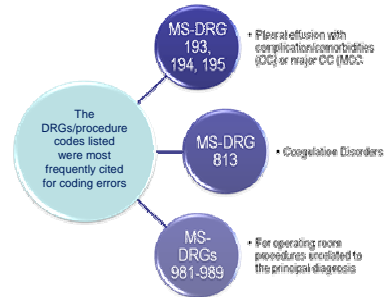
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## Coding

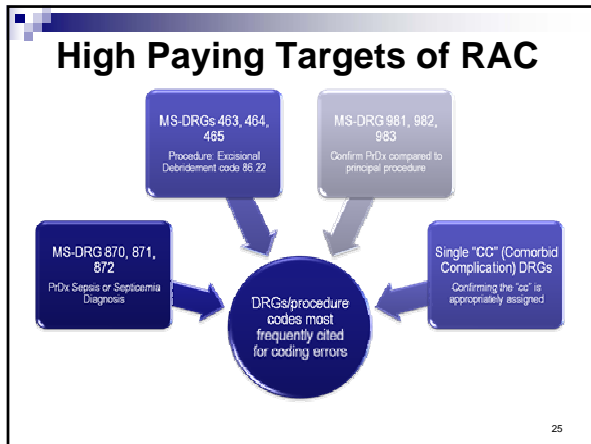
- Coding denials did not remain the focus of RAC
- By the end of the demonstration project, medically unnecessary settings appeared to have taken its place
- Accurate coding will continue to be one of the areas the permanent RACs will review
- A good proactive program that ensures accurate coding and appropriate medical settings and services is essential

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## High Volume Targets of RAC



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## RAC Complex Review – Incorrect Coding

### Wrong Principal Diagnosis

- Principal Diagnosis on claim did not match diagnosis in the medical record
- RAC found the principal diagnosis submitted on the claim was Respiratory Failure (518.81) medical record supports Sepsis (038-039)
- RAC requested a repayment letter for the difference between the DRG payments

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## RAC Coding Issues: Excisional Debridement – 86.22

- Reporting of excisional debridement (86.22) w/o adequate medical record documentation to meet the definition of "excisional."
  - MS-DRGs 463, 464 and 465
  - 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 clinicians
      - May need to revise documentation forms

1<sup>st</sup> Qtr 2008 – new guidance from AHA... review

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## RAC Coding Issues Single "CC" / MCC DRGs

### DRGs designated as CC or MCC with only one secondary diagnosis. i.e.,

- MS-DRG 329 Major Small & Large bowel with MCC
  - 4.5059
- MS-DRG 330 Major Small & Large bowel with CC
  - 2.8935
- MS-DRG 331 Major Small & Large bowel w/o cc/MCC
  - 1.8415

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## Discharge Status

### Coding Targets:

- Correct coding of discharge status for post-acute care transfer
- Patient discharged from hospital with improper discharge status on claim

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## Discharge Status

**Example of "Incorrect Discharge Status" Automated Review Audit**

	Dates of Svc	Discharge Status Code	Amount Paid
Claim #1:	8/21 – 23/04	01 (home)	\$2,606.00
Claim #2:	8/23 – 27/04	02 (hospital)	\$2,526.10

**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

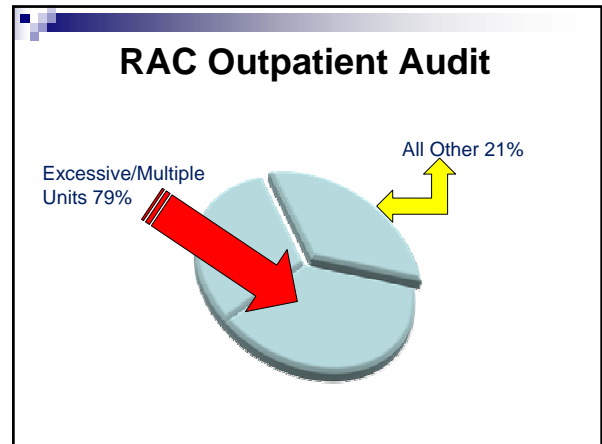
**CORRECTIVE ACTIONS**

- 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

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MS DRG	Description	Number of Cases	Hosp. Comp. Rate	Benchmark Urban 100-199 Beds	Hospital MCC Rate	Benchmark MCC Rate	Hospital CMI (For Compared DRG)	Benchmark CMI (For Compared DRG)	Hospital Number of Cases with only one "CC"	Hospital Total Number of Cases with "CC"	Hospital Number of Cases with only one "MCC"	Hospital Total Number of Cases with "MCC"
370809	Extracranial Procedures	21	14.3%	26.1%	0%	6.9%	1.1449	1.2439	1	3	0	0
646666	Cerebral Hemorrhage & Infarct	32	75%	63.9%	9.4%	21.4%	1.1636	1.2089	5	20	1	3
175176	Pulmonary Embolism	22	91%	22.9%	9.1%	22.9%	1.1614	1.2170	NA	NA	1	2
177170	Respiratory Infections & Inflammation	50	78%	83.9%	34%	39.8%	1.5967	1.6288	16	22	11	17
291280	Heart Failure & Shock	67	62.7%	68.8%	20.9%	32.0%	1.0135	1.0464	19	27	9	14
871672	Septicemia w/o MI > 96 Hours	38	68.4%	70.4%	68.4%	70.4%	1.6315	1.6389	N/A	N/A	18	20



### Outpatient Services

**Example of an "Excessive Units" Automated Review Audit**

Date of Service	Procedure	Units	Amount Paid
3/1/04	47562 (Cholecystectomy)	3	\$2,461.23

**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

### Examples - Outpatient Services

**Injection, pegfilgrastim 6mg (J2505) -- Neulasta**

- INCORRECT CODING:** Provider billed one service per 1 mg but definition of this code is one service per 6 mg vial. A provider administered 6mgs of Neulasta to the beneficiary but billed for 6 units of J2505. According to the definition of the code, six units of J2505 would be 36 mg of Neulasta.

**Speech/hearing therapy (92507)**

- INCORRECT CODING:** Provider billed one service for each 15 minutes but definition of this code is one service per session. A therapist provided a 45 minute session of therapy to the beneficiary but billed for 3 units of 92507. According to the definition of the code, three units of 92507 would be for 3 separate sessions of therapy on the same day.

### Examples - Outpatient Services

**Blood transfusion service (36430)**

- INCORRECT CODING:** Provider billed one service per pint of blood but definition of this code is one service per transfusion session. An emergency room provided one transfusion session during which 2 pints of blood were administered to the beneficiary. But the hospital billed for 2 units of 36430. According to the definition of the code, two units of 36430 would be for 2 separate transfusion sessions in the same day.

**Number of procedures per day (e.g., appendectomy, colonoscopy) (automated review)**

### Physician Focus Areas

- Evaluation and Management Services-**
  - All evaluation and management services that were billed during a global period, duplicate claims for evaluation and management services, consultations and evaluation and management services billed with procedures are all potentially reviewable by RAC.
  - All evaluation and management services submitted with modifier 24 could be subject to review.
- Medical Necessity-**
  - Ensure that your services meet the medical necessity edits found in the National Coverage Decisions.
  - Ensure that the diagnosis is adequately documented in the medical record for the patient. (Example: Procedures to Pharmaceutical J Codes).

## Physician Focus Areas

- **Unbundling of procedures-**
  - Keep current with NCCI initiative to ensure that the practice is not billing for more procedures than is appropriate. (Example: Billing for unilateral CPT code twice when another CPT code is applicable for bilateral services billed once.)
- **Place of Service Codes-**
  - Ensure that the correct place of service is reported. (Example: billing as an office place of service for provider-based clinics).
- **Units of Service-**
  - From X-ray to pharmaceuticals injections, ensure that the correct number of units is reported. Excessive units and utilization will be subjective to review.
- **Vestibular function testing-**
  - These services are addressed in Medicare Claims Payment Manual, Chapter 15- Covered medical and other healthcare services RAC will be looking for proper ordering guidelines and services performed by qualified personnel, and ensuring sufficient medical necessity is documented. Note: Cigna Government Services does not currently have a LCD for this testing.

## Physician Focus Areas

- **Billing for Non-Covered services as covered services-** for example, cosmetic procedures.
- **Duplicate Claims-** Claims billed and paid twice for the same service.
- **High Volume Services-** Any CPT code that is billed at a high volume for any provider regardless if a NCD or LCD exists will be subject to review by RAC.
- **“Incident to”-** RAC will be looking for NP’s or PA’s who perform new patient services for and bill under the physician’s number.

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## Targeted RAC Reviews – “Data Mining”


Use of proprietary data mining tools that identify cases with the greatest probability of change

- Drills down from DRG or procedure to
- ICD-9-CM diagnosis and procedure codes
- Charges
- Length of stay

You need to be “Data Mining” also

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## Polling Question



Has your facility developed or outsourced a data mining process?

26% Yes  
68% No  
5% Under Discussion

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## Regulatory Risk – Incorrect Payment Amounts, Non-Covered Services, Duplicate Services

## Revenue Cycle Components

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

- Do your findings match the RAC concerns?
- How have you addressed the past?
- Do you see any trends in your review data?
- Did you measure inpatient medical necessity?

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## Where is the "Twist?"

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## Are You in *Denial* Over Your Denials?

- A 2007 Health Care Study found that both hospital executives and insurers believe their organizations are highly efficient when it comes to administration of claims and billing.
- However, the prevalence of redundant processes and high error rates in claims would indicate the opposite is true.

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## Are You in *Denial* Over Your Denials?

- For example, 1 in 5 claims submitted is delayed or denied.
- 96% of all claims submitted in an average month must be resubmitted at least once.
- According to a report from the Health Care Advisory Board, the cost of denials to hospitals ranges from 1% to 3% of total revenue.

## What Is A Denial?

## Polling Question

A good denials management and resolution program includes a denials database and standardized reports. Do you have a standardized business office methodology to resolve denied accounts?

- 37% Yes
- 0% No
- 39% Unknown
- 24% Under Discussion

## Mechanics of the Process

Currently

- Fiscal Intermediary Standard System (FISS) adjusts a claim and if there are claims in the system, immediately recoups.

Future

- Contractor (RAC) has determined the overpayment and adjusted the claim in FISS system, the withholding of the overpayment will automatically be set to begin withholding 46 days from the determination date.

## RAC Collection Process

### Automated Review

- Basically the same collection process with the RAC program as the carrier, FI and any MAC identified overpayment.
- The difference is that the demand letter is coming directly from the RAC.
- You will receive a remittance advice with a code N432 Adjustment Based on Recovery Audit.
- At that point, the RAC will issue the demand letter and the carrier, the FI, the MAC will recoup via offset.
- Choices after receiving the demand letter:
  - Allow recoupment
  - Pay by check
  - Stop recoupment by filing your appeal
  - Sign up for an extended repayment plan

## RAC Collection Process

### Complex Review

- Review issue is posted to the website followed by the RAC issuing a **medical records request**.
- There is a 45 day period to submit medical records. Mailroom time gives you a total of 55 calendar days to respond.
- A denial will result if the record is not received in 55 days.
- You will receive a **review results letter**. It does not contain appeal right information nor does it contain how much money the RAC identified as an error.
- You will receive a RA with code N432 and a demand letter which will have your appeal right information, amount you owe, and interest begins to accrue.
- Day 41 recoupment takes place.

## Will CAH be subject to RAC review? If so, how will the funds be recouped?

Yes, Critical Access Hospitals are subject to RAC review. Any adjustments will be reflected on the final PS&R. If the cost report has already had a final settlement, the amount will be demanded and then offset against future claims if not paid in full by the provider.

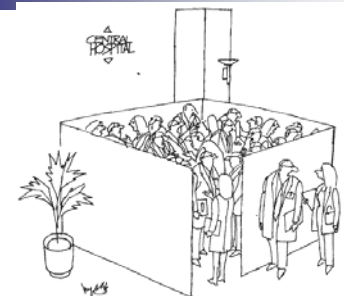
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## Prepare Strategy Document

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 all documentation and communication
  - Failure to submit the requested record in 45 days will result in denial.



"They think it's free lunch, but they're actually our **RAC Committee** volunteers."

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## Revenue Integrity Team

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



## Have Both Defensive and Offensive Strategies

### Vigorously appeal medical necessity denials

- Medical necessity is inherently subjective
- LCDs have often been subjected to serious clinical scrutiny and change often

### Identify underpayments on both RAC targeted claims and other

- Request waiver of timely filing deadlines for identified underpayments

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## Dedicated Staff

- 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

## Providers' Records

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

## What is our inspiration to keep on going?

- To address identified issues with incomplete documentation
- To improve the accuracy of DRG assignment
- To improve the specificity of coding
- To provide meaningful data for use in reporting and physician profiling
- To increase the accuracy of the hospital case mix index (CMI)
- To expand working relationships with ancillary staff
- To provide reliable data that influences change at my facility
- To ensure our revenue picture is certain
- To ensure the integrity of our financial statements
- To provide reliable data that influences our revenue integrity

## Best Practices

- Locate and send records within established time frame
- Send information that requires signature on delivery
- Create tracking process from point of arrival through settlement
- Verify with MAC who the contact person on file is
- Establish clear internal appeals process
- Define ownership and accountability
- Include clinical and medical staff in all medical necessity concerns

## Permanence

## Compliance Solutions



- RAC could be an important opportunity to enhance compliance and streamline billing concerns.
- Evaluating all the assets, strengths, and weaknesses in your revenue cycle will be crucial to formulating a seamless process to ensure issues are identified and corrected before the RAC identifies them.

## Create? Redesign?

Start by assembling team from multiple departments

Providers/hospitals should track & trend all requests for regulatory review.

- 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

## Proactive Approach

- Data Analytics is a 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 a RAC team that works for your facility

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## Establish a Sense of Permanence

- Define structure for charge process
- Perform charge reconciliation
- Report findings daily
- Department manager accountability for continued risk
- Define disciplinary guidelines

## Core Tasks for RAC Response

- Monthly meetings with RAC team
- Weekly conference calls with RAC coordinators
- Physician one on one education on denial specific information
- On site participation with team meetings, chart review, education and review of recent denials
- Quarterly conference calls with RAC coordinators collectively from each group
- Quarterly meeting with System leadership

## Have both Defensive and Offensive Strategies

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Identify underpayments on both RAC targeted claims and other

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## Realities

Burdensome

Costly

In many ways

- Time-consuming
- Frustrating
- Sometimes embarrassing

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