Are you ready for RACs?
Recovery Audit Contractors

Sandra S. Lentz, RN
Manager
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Session Overview

- Brief overview of the RAC Initiative
- Updates to Permanent RACs
- Home Health Issues
- Compliance
- Challenges/Opportunities
RAC OVERVIEW
Overview of the RAC Initiative

- Section 306 of the Medicare Modernization Act
  - Directed CMS to investigate Medicare claims payments using RACs under a three year demonstration project
  - California, Florida and New York were initially chosen for the demonstration project
Legislative Authority

Section 306 – Medicare Modernization Act
- Requires Secretary of Health and Human Services to test the use of Recovery Audit Contractors (RAC) for identifying Medicare Part A and B underpayments and overpayments, and recovering the latter
- At least two states with high Medicare utilization
- May not use existing contractor
- May compensate based on percent of recovery
  - Previously prohibited for Medicare
- No more than three years
- Report to Congress
  - Six months after completion
  - Recommendations for extending/expanding project
Recovery Audit Contractors

Mission: 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.
RAC Design

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

- RACs
  - Paid on a contingency basis;
  - July 2007 the project expanded Arizona, South Carolina, Massachusetts
“The RAC demonstration program has proven to be successful in returning overpayments to the Trust Fund and identifying ways to prevent future improper payments. We will use the lessons we learned from the demonstration program to help us implement the national RAC program next year”

Acting CMS Administrator Kerry Weems
Overview of the RAC Initiative

RACs are not intended to replace other review efforts by Fiscal Intermediaries, Part B and DME Carriers, Program Safeguard Contractors (PSC), Benefit Integrity Support Centers (BISC) Quality Improvement Organizations (QIO) or the Office of Inspector General (OIG)
Overview of the RAC Initiative

- Guided by same Medicare policies & rules as MACs
- Contractors identify & collect Medicare claims improper payments not identified by carriers, FIs & DMERCs
- Since CMS began the program, the error rate has dropped from 14.2 percent in 1996 to 3.9 percent in 2007

Tasks:

1. Identify & Recoup  
2. Support CMS in developing improper payment prevention plan  
3. Educate provider communities on RAC’s purpose
Figure 5. Overpayments Collected by Provider Type: Cumulative Through 3/27/08, Claim RACs Only

- $59.7 Million Inpatient Rehabilitation 6%
- $16.3 Million Skilled Nursing Facility 2%
- $44.0 Million Outpatient Hospital 4%
- $19.9 Million Physician 2%
- $5.4 Million Ambulance/Lab/Other <1%
- $6.3 Million Durable Medical Equipment 1%
- $828.3 Million Inpatient Hospital 85%

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).
Figure 6. Overpayments Collected by Error Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

- $391.3 Million Medically Unnecessary 40%
- $160.2 Million Other 17%
- $74.3 Million No/Insufficient Documentation 8%
- $331.8 Million Incorrectly Coded 35%

Source: Self-reported by the Claim RACs.
Demonstration Results

RACs collected $980 million dollars,
March 2005 – March 2008

Overpayments Collected by Provider Type
- Inpatient Hospital: 84%
- Outpatient Hosp/IRF/SNF: 14%
- Physician/Ambulance/Lab/Other: 1.5%
- DME: 1%

Overpayments Collected by Error Type
- Medically Unnecessary: 40%
- Incorrectly Coded: 35%
- Other: 17%
- No/Insufficient Documentation: 8%

SOURCE: RAC Data Warehouse

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Reasons for RAC Demonstration

- Medicare medical review and payment error rates
- Claimed effectiveness of RAC’s proprietary software
- Experience of states and other federal agencies
- Collection without additional cost
RAC Demonstration

- Excluded overpayments and underpayments
  - Services other than Medicare fee-for-service
  - Cost report settlement process
  - Incorrectly coded services
  - Claims under one year or over four years old
  - No random claims selection
  - No prepayment review
Issues Identified

- Issues identified within hospital inpatient/outpatient, physician and DME.
- Home Health & Hospice not included in the demonstration project.
- Projected course of action based on revenues:
  - Hospital (Inpatient/outpatient),
  - Physician practice,
  - Skilled nursing facility,
  - Rehab centers,
  - Long term care centers,
  - Durable Medical Equipment,
  - Home Health, and
  - Hospice.
## History – Demonstration Results

### Claim RACs Appeals Data

Provider Appeals of RAC-Initiated Overpayments  
Cumulative through 3/27/08 – Claim RACs Only

<table>
<thead>
<tr>
<th>All Claim RACs</th>
<th># of Claims with Overpayment Collections</th>
<th>ClaimsAppealed By Provider to Any Level</th>
<th>Appealed Claims with Decision in Provider’s Favor</th>
<th>Percentage of Overpayment Determinations Overturned on Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>556,878</td>
<td>76,659</td>
<td>13.8%</td>
<td>25,384</td>
</tr>
</tbody>
</table>

Source: RAC Data Warehouse and data reported by Medicare claims processing contractors. Includes both completed appeals and those currently pending in the appeals process. These statistics are based on appeals that were known to the Medicare claims processing contractors on or before 3/27/08.
Permanent RAC Contractors

- Diversified Collection Services, Inc. of Livermore, California, Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.

- CGI Technologies and Solutions, Inc. of Fairfax, Virginia, Region B, initially working in Michigan, Indiana and Minnesota.


- HealthDataInsights, Inc. of Las Vegas, Nevada, Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.
2008 RAC Jurisdictions

HealthDataInsights

CGI Technologies

Diversified Collection Services

Connolly Consulting Services
RAC Expansion

- Tax Relief Act of 2006, section 302: makes RAC program permanent and nationwide by no later than 2010
Avoid Interference with MAC Transition

- RAC black out period will allow new MACs to focus on claims processing activities
  - There will be a RAC blackout period for:
    - 3 months before a MAC begins processing claims
    - 3 months after a MAC begins processing claims
RAC Announcement

- Late September 2008
- CMS/RACs to conduct outreach educational program to providers in first round
  - 4-6 weeks if existing RAC
  - 8-12 weeks if new RAC
- RAC audits begin 4-6 weeks after CMS/RAC education with state provider association(s)
## MAC-RAC Jurisdictions

<table>
<thead>
<tr>
<th>State</th>
<th>MAC</th>
<th>RAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>4-Trailblazer-Spring</td>
<td>C-Summer 08</td>
</tr>
<tr>
<td>New Mexico</td>
<td>4-Trailblazer-Spring</td>
<td>C-Summer 08</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>4-Trailblazer-Spring</td>
<td>C-Fall 08</td>
</tr>
<tr>
<td>Texas</td>
<td>4-Trailblazer-Spring</td>
<td>C-Fall 08</td>
</tr>
<tr>
<td>Arkansas</td>
<td>7-(Pinnacle Business Solutions 6/08) C-Jan 09</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>7-(Pinnacle Business Solutions 6/08) C-Jan 09</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>7-(Pinnacle Business Solutions 6/08) C-Jan 09</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>9-(Award 9/08)</td>
<td>C-Summer 08</td>
</tr>
<tr>
<td>Tennessee</td>
<td>10- (Award 9/08)</td>
<td>C-Jan 09</td>
</tr>
<tr>
<td><strong>Alabama</strong></td>
<td><strong>10- (Award 9/08)</strong></td>
<td><strong>C-Jan 09</strong></td>
</tr>
<tr>
<td>Georgia</td>
<td>10- (Award 9/08)</td>
<td>C-Jan 09</td>
</tr>
<tr>
<td>South Carolina</td>
<td>11- (Award 9/08)</td>
<td>C-Summer 08</td>
</tr>
<tr>
<td>North Carolina</td>
<td>11- (Award 9/08)</td>
<td>C-Jan 09</td>
</tr>
<tr>
<td>Virginia</td>
<td>11- (Award 9/08)</td>
<td>C-Jan 09</td>
</tr>
<tr>
<td>West Virginia</td>
<td>11- (Award 9/08)</td>
<td>C-Jan 09</td>
</tr>
</tbody>
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RAC Scope of Work

What RACs may *not* review:

- Services provided under a program other than Medicare FFS (i.e., Medicare Advantage)
- Cost report settlement process (IME or GME payments)
- Claims more than 3 years past the claim paid date.
- Claims paid earlier than October 1, 2007.
- Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayment.
- Claims in a demonstration program or with special processing rules
- Prepayment Review
The Process

- The RAC will send a medical record request letter to the provider containing the rationale for each request.
- Provider has 45 days to respond
  - No response will lead to an administrative denial.
- RACs have worked with providers who cannot meet the 45-day deadline.
- RAC has 60 days to make determinations after receiving the records
  - Extensions granted by CMS.
- Follow appeals process for those cases in which provider disagrees with RAC determination.
Request For Records

CMS announced limits on the number of medical records the RACs

- Other Part A Billers (Outpatient Hospital, Home Health, etc) by NPI
  - 1% of average monthly Medicare paid services per 45 days
  - Maximum of 200 medical records per 45 days
Request For Records

- Example 1:
  - 1,500 Medicare paid services in 2007
  - Divided by 12 = avg 125 Medicare paid services per month x 1% = 1.25
- Limit = 2 records/45 days
Request For Records

Example 2:

- 360,000 Medicare paid services in 2007
- Divided by 12 = avg 30,000 Medicare paid services per month x 1% = 300
- Limit = 200 records/45 days (capped at the maximum)
Request For Records

- The RACs will not be able to request more than 200 records in a 45-day period.
- Providers with more than one NPI may face a unique record limit per NPI; however, CMS to provide further clarification on this policy.
RAC Scope of Work

Types of RAC audits:

- Automated review occurs when a RAC makes a claim determination without a human review of the medical record. RACs use a proprietary software that is designed to detect certain types of errors. In order to make a coverage or coding denial using automated review, both of the following conditions must apply.

  - First, there must be certainty that the service is not covered or is incorrectly coded.
  - Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more than allowed on one day.
Overview of RACs

Types of RAC “Targeted” Reviews

- **Automated**
  - No medical records involved in the review, certainty that overpayment exists based on data review
  - Provider notified of review resulting in overpayment
  - RAC not required to notify provider if no overpayment identified
  - MSP reviews are conducted through automated process
  - Inform provider of coverage/coding/payment policy violated
  - Uses proprietary software, experience and resources to identify overpayment
RAC Scope of Work

- Complex review
  - RAC makes a claim determination using human review of the medical record.
  - Complex review is used when there is a high probability (but not certainty) that a service is not covered or where no Medicare policy, Medicare article or Medicare-sanctioned coding guideline exists.
  - The RAC will need copies of medical records to provide support for its decisions. Most of the focus of complex reviews has been medical necessity determinations.
  - Records may be sent in paper form, CD’s, DVD, or Fax
# RAC Demonstration vs. Permanent

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

- CMS to publicly release the contingency fee rates paid to RACs
- CMS will publicly release each permanent RAC’s accuracy score
- Provider outreach
  - CMS/RAC visits
  - Posting of issues on RAC Web sites with link to coding guidelines, CMS manuals, local policies, etc.
RAC Demonstration Report-Press Release

- When a new RAC begins to issue its first overpayment notification letters, it will be limited to “black-and-white” billing issues, such as duplicate claims and wrong fee schedule amounts, etc.
Other Issues for Consideration

- Issue of extrapolation in the Statement of Work
- Impact of RAC reviews on voluntary disclosure and repayment
- Reduced contingency fee for funds refunded pursuant to self-disclosure
  - Identified vulnerability must be included in their project plan
The Issues that Continue

- Contingency fee-based payments
- Medical necessity determinations
- Look back period
- Ability to rebill denied claims
- Move to electronic communications
- Increased transparency; need for report card
- Provider education
Claim Reviews

How many years of claims is a RAC permitted to review?

As the program progresses over time, RACs may not identify overpayments or underpayments that are more than three years past the date that the claim was originally paid, but in no case may a claim paid prior to October 1, 2007 be reviewed by a RAC.
RAC UPDATE – SOUTH CAROLINA

- July 11, 2008, facilities sue HHS over RAC demonstration process
- Thirty-two South Carolina facilities and hospital systems have sued the Department of Health and Human Services and Centers for Medicare & Medicaid Services in federal court for illegally recouping about $30 million in alleged Medicare overpayments during the Recovery Audit Contractor demonstration project.
RACs on HOLD

- The Centers for Medicare & Medicaid Services (CMS) is required to impose an automatic stay in the contract work of the four Recovery Audit Contractors (RAC) program. This action is the result of protests filed by two unsuccessful bidders for the RAC program with the Government Accountability Office (GAO).
RACs on Hold

- An automatic stay will stop work for all four RAC regional awards
- Under the CICA, GAO has 100 days to issue its decision, which means a decision would be due for these protests in early February. The four RAC contracts – and any work under those contracts – are on hold pending the outcomes of the protests.
Issues?? Home Health??

What issues can be identified in Home Health?
# Top 20 Service Types with Highest Improper Payments: FIs

<table>
<thead>
<tr>
<th>Service Type Billed to FIs (Type of Bill)</th>
<th>Projected Improper Payment</th>
<th>Paid Claims Error Rate</th>
<th>95% Confidence Interval</th>
<th>Type of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No Documentation</td>
<td>Insufficient Documentation</td>
</tr>
<tr>
<td>OPPS, Laboratory (an FI), Ambulatory (Billing an FI)</td>
<td>$384,307,290</td>
<td>2.2%</td>
<td>1.7% - 2.6%</td>
<td>4.8%</td>
</tr>
<tr>
<td>SNF</td>
<td>$235,158,148</td>
<td>1.5%</td>
<td>1.0% - 2.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td>HHA</td>
<td>$78,401,077</td>
<td>0.8%</td>
<td>0.3% - 1.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other FI Service Types</td>
<td>$76,851,903</td>
<td>2.1%</td>
<td>1.0% - 3.1%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Hospice</td>
<td>$61,048,433</td>
<td>1.0%</td>
<td>0.1% - 1.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>ESRD</td>
<td>$37,181,187</td>
<td>0.7%</td>
<td>0.4% - 1.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Non-PPS Hospital Inpatient</td>
<td>$28,093,371</td>
<td>0.8%</td>
<td>0.3% - 1.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>FQHC</td>
<td>$3,802,461</td>
<td>1.1%</td>
<td>0.1% - 2.1%</td>
<td>20.8%</td>
</tr>
<tr>
<td>RHCs</td>
<td>$2,292,100</td>
<td>0.5%</td>
<td>0.2% - 0.9%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Free Standing Ambulatory Surgery</td>
<td>$7,169</td>
<td>0.0%</td>
<td>0.0% - 0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>All Type of Services (Incl. Codes Not Listed)</td>
<td>$907,143,140</td>
<td>1.4%</td>
<td>1.2% - 1.7%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

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Top Home Health Denial Reason Codes

- **5F041/5A041 - Information Provided Does Not Support the Medical Necessity for All or Part of This Service**

- **Reason for Denial**
  - This claim was fully or partially denied because the clinical documentation submitted for review did not support the medical necessity of the skilled services billed. For example, the submitted documentation may have indicated there was no longer a reasonable potential for change in the medical condition, or sufficient time had been allowed for teaching or observation of response to treatment.
Top Home Health Denial Reason Codes

- 56900 - Lack of Response to Medical Record Request (Refer to Section 2 – Denial Reason Code 56900)

Reason for Denial

- Information not submitted within the required time frames for the ADR
Top Home Health Denial Reason Codes

- **5DOW1 - Medical Review Downcode/Documentation Contradicts M0 Item(s)**

- **Reason for Denial**
  - The clinical documentation submitted for review contradicted points taken in one or more M0 item responses on the OASIS. As a result, the HIPPS code was affected and reimbursement was made at a lower payment level.
Top Home Health Denial Reason Codes

- 5ADSD - Dependent Services Denied

Reason for Denial

- The dependent services were denied because the qualifying service was medically denied
Top Home Health Denial Reason Codes

- 5DOW3 - Partial Denial of Therapy Resulting in Medical Review Downcode
- 5F301/5A301 – Information Provided Does Not support the Medical Necessity for Therapy Services

Reason for Denial

- Based on the medical record submitted for review, the therapy visit(s) billed was/were not covered. As a result, the HIPPS code was affected and reimbursement was made at a lower payment level.
- The therapy visits were not covered because the documentation submitted did not support the medical necessity of these services.
Automated Examples

- Lowest HIPPS Code Continues to Have Higher Homebound Denials
  - Low clinical severity, and are highly functional, according to OASIS

- Widespread Probe Results and Review Notification for Home Health Claims with a Diagnosis of Hypertension
  - The topic code for this review will select HH PPS claims with a diagnosis of hypertension in at least the third episode
Automated Examples

- Long Term Use of Anticoagulants—Widespread
  - Over 82 percent of the charges reviewed for this edit from January 1, 2008—March 31, 2008 were denied.
  - This edit requests claims for beneficiaries in their second or greater episodes of care, with no therapies, and a primary diagnosis of V58.61
Complex Examples

- Longer-Term Patients with COPD Continues to Lack Supportive Documentation
  - Recertification home health with a primary diagnosis of Chronic Airway Obstruction (ICD-9-CM 496) and a length of stay greater than 120 days. Analysis of the denials for this edit identified the main issue as a lack of documentation to support ongoing skilled nursing in the home.
Complex Examples

- One Skilled Nurse and Occupational Therapy Continues
  - To be considered reasonable and necessary, the services must be consistent with the nature and severity of the illness or injury, the patient’s particular medical needs, and accepted standards of medical and nursing practice.
  - Routine nursing evaluations post-hospitalization to check medication management, home safety, etc. are not considered medically necessary. Nursing visits to complete the OASIS are an administrative cost, and are not billable.
Preparation
What Can I Do To Prepare?

- Start by assembling team from multiple departments
  - Senior Administration
  - Finance
  - Coding
  - Clinical Staff
  - Quality Management
  - Therapy/contract
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
Proactive Approach – Just What the Doctor Ordered

- 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 RAC team that works for your facility
RAC APPEALS

Defend Data
Mechanics of the Process

Responding to a RAC Record Requests

- Providers must respond to request for records by the 45th day of the request
- Providers may request an extension at any time prior to the 45th day by contacting the RAC

Appealing Denials

- Standard CMS appeal processing timelines
- First level inpatient (IP) appeals handled through FI rather than QIO
- All non-IP services handled through standard processes
Mechanics of the Process

Recoupment-
the recovery of a Medicare overpayment by reducing present or future Medicare payments and applying the amount withheld against the debt.

Appeal-
the examination of the validity of the overpayment.
Mechanics of the Process

- Federal Register / Vol. 71, No. 184
  September 22, 2006
  Limitation on Recoupment of Provider and Supplier Overpayments

- Transmittal 322 – CMS Manual
  Pub 100-20 One-Time Notification, March 5, 2008
  effective: July 1, 2008
  implementation date: July 7, 2008

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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 40 days from the determination date.
Mechanics of the Process

First Appeal

If an appeal was submitted by the provider within those 40 days the withholdings will not begin.
Mechanics of the Process

The FISS System shall search all claims adjustments submitted and flagged with a Reason/Discovery code for all RAC claims adjustments and bypass the demand letter issuance to the provider. All other requirements shall be followed for these adjustments with the exception of the issuance of the demand letter through FISS.
Compliance Solutions

- Monitor FISS System to ensure claims adjustments are following the right path
- Develop guidelines that define “who” and “when” issues need to be passed on
- Where is the first line of notification and whose name is on the “contact” list for payment issues?
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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Compliance Solutions

Education

- Senior Management
- Administration Management
- Coding professionals
- Billing Managers/staff
- Supervisors
- Quality/Performance Management
- Case managers
Create Your Opportunities
Current Compliance Plan Says

1. Educate & Train
2. Audit & Monitor
   - High risk
   - High volume
   - Address identified trends
Recent Assessments

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

Missing opportunities –
    Certified coders
    Accurate code descriptions
    Improve principal diagnosis
    Files management inventory
    Physician Query Process
    Accountability and responsibility in documentation for all disciplines.
Best Practices

- Develop “mock” practice files
- Identify if your agency can locate and send records within established time frame
- Do you currently send information that requires signature on delivery to FIs or other reimbursement parties?
- Have you created a tracking process from point of arrival through settlement?
- You should verify with FI/Carrier and RAC who is named the contact person within their files.
Best Practices

- Establish clear internal appeals process
- Define ownership and accountability
- Educate clinical, data input and billing staff in all identified trends
- Manage two (2) case mix scores for the agency: one with RAC impact and one which reflects patient’s served
Establish a Sense of Permanence

- Define structure for RAC process
- Require weekly written reports on RAC file status
- Discuss accountability for continued risk patterns
- Define disciplinary guidelines
Have Defensive and Offensive Strategies

- Vigorously appeal medical necessity denials
  - Medical necessity inherently subjective
  - LCDs have not 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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Be Prepared!

- Need for data collection tool
- RAC committee
- Single point of contact
- Know the rules
  - Medicare HH Regulations
  - RAC Scope
- Prioritize record reviews
  - High Risk
  - High Volume
  - Denial Trends
- Defend! Defend! Defend!
  - Support your claims
Realities

- Burdensome
- Costly
- In many ways
  - Time-consuming
  - Frustrating
  - Sometimes embarrassing
Helpful Links to Public RAC Documents

- CMS FY 2007 RAC Status Document

- CMS FY 2006 RAC Status Document

- CMS RAC – Frequently Asked Questions

- CMS Expansion Schedule for the RACs (Map of States and Timing of RACs)

- CMS RAC Statement of Work (go to November 7, 2007)
  https://www.fbo.gov/?s=opportunity&mode=form&id=3e216d24c897ec7882beb2424f03b9b9&tab=core&_cview=1
Questions?

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