The RAC Toolkit

for Hospitals and Health Systems

*Manage Responses and Avoid Claims
Under the Permanent Program*

ELIZABETH E. LAMKIN, MHA
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HCPro

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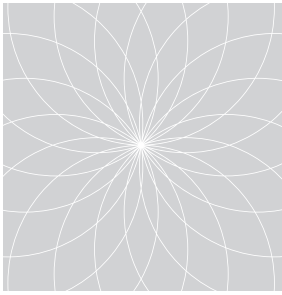
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About the Authors

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Elizabeth Lamkin has more than 20 years of executive experience in the nonprofit, clinical teaching, and investor-owned healthcare sectors. She served as market president and CEO for Hilton Head Regional Healthcare (Tenet) where she developed a successful Recovery Audit Contractor (RAC) strategy during the demonstration project. Prior to that, she held positions as chief operations officer for North Fulton Regional Hospital (Tenet) in Roswell, GA; regional CEO for four inpatient hospitals for HEALTHSOUTH in Arizona; CEO for HEALTHSOUTH in Charleston, SC; and served as administrator for Palmetto Health Heart Hospital in Columbia, SC. She is currently CEO of PACE Healthcare Consulting, LLC, which provides a broad range of strategic and tactical services for hospitals and healthcare providers. Lamkin holds a bachelor of arts *cum laude* and a master's in health administration from the University of South Carolina. Because of strong operational, quality, and strategic successes, Lamkin brings a unique, global CEO perspective to surviving RAC and other billing compliance issues.

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With more than 10 years of experience in healthcare and biotechnology, combined with degrees in business and engineering, Berglund works with clients on projects that require detailed analysis, systematic business case development, comprehensive implementation, and continued measurement. Prior to joining PACE Healthcare Consulting, LLC, Berglund was chief business development officer at North Fulton Regional Hospital in Roswell, GA, where she was responsible for all aspects of business development. She has also worked in Arthur Andersen's healthcare consulting division, where her projects included strategic planning, revenue-cycle development, cost containment strategy development, and policy manual development. Berglund holds a bachelor of science from Columbia University, a master's of science from Georgia Institute of Technology, and a master's of business administration from Nova Southeastern University.
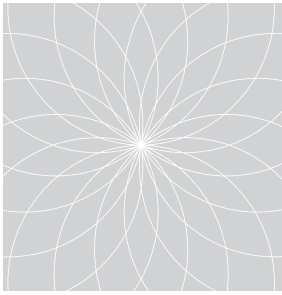
Acknowledgments

We would like to thank ...

Laurie Jaccard, President, Clinical Intelligence, LLC, who was especially helpful to the authors in providing editing advice and in developing some of the figures included in this book. Laurie is a registered professional nurse and a 1986 graduate from Presbyterian Hospital School of Nursing in Charlotte, NC. As an RN, Laurie has 20 years of diversified critical care, performance improvement, and outcomes management experience, and she has continued her education with courses in business, research, statistical application, and quality improvement. She has a proven track record for creating "value-added" care management programs by teaming with physicians to customize tools that translate evidence into practice, drive data into action, and provide user-friendly and quality approaches to patient care.

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Donna Turtle, RN, BSN, MPH, for her guidance and advice on the writing of the book from a clinical quality and care management perspective. Turtle has extensive hospital operations experience, both clinical and financial, specializing in care management systems redesign, revenue enhancement, and patient throughput improvement. Her most recent position as associate vice president for a healthcare management and consulting firm culminates more than 15 years in the hospital and managed care industry, including operational analysis, interim support, redesigned systems implementation, and care management training.

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Judy D. Benjamin for her editing help and contributions. With more than 25 years of experience in the healthcare industry, Benjamin is considered to be an engaging and effective thought leader who applies a pragmatic approach to all consulting engagements. Benjamin specializes in strategic planning and all aspects of business development for community hospitals, multihospital health systems, physician groups, and emerging healthcare companies.

Bill Malm, ND, for his collaboration on the development of this material and his partnering with Elizabeth Lamkin on several nationally broadcast webinars on the Recovery Audit Contractor (RAC) process. Malm works with CraneWare, Inc., and is a nationally known author and speaker on topics such as compliance, chargemasters, and postpayment recoupment audits such as RAXC. To learn more about Malm and his company, CraneWare, please visit *www.craneware.com*.

Randy Lamkin, PhD, for his help in understanding what makes an effective meeting. Lamkin earned a PhD in sociology from the University of Connecticut and has taught at the University of South Carolina (USC) in Columbia, USC-Beaufort, the College of Charleston, and Scottsdale Community College. He was president of an organizational development and training company specializing in team building, planning, and quality improvement, and also served as director of educational services at Richland Memorial Hospital in Columbia, SC.
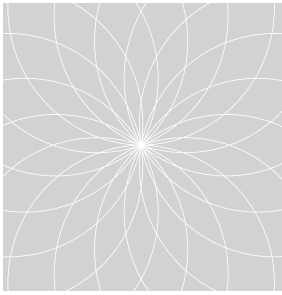
Introduction:
A Successful Approach to
RAC Is Driven from the Top

If you are reading this book, you understand the Recovery Audit Contractor (RAC) program has tremendous implications for your facility's financial viability. The Office of Inspector General and Centers for Medicare & Medicaid Services (CMS) will continue to expand the RAC program and compliance requirements; if you are not prepared today, the consequences could be great.

Our goal in writing this book was twofold: 1) to help facilities effectively approach, prepare for, and respond to individual RAC audits, and 2) to help facilities improve the overall billing compliance program through specific changes to their organizations' structures, processes, and people. It is this second purpose that requires changes to the organizational structures, processes, and people that must be championed by the leaders within the facility. The magnitude of the financial, licensure, and compliance risk associated with RAC and improper billing elevates RAC to the top of the organization, but everyone in the organization needs some education on the program to ensure that change is effective and sustainable.

The CEO has the responsibility to report all compliance issues and risk to the governing board (GB). Top leadership should drive the RAC process because it is not just the repayment of improper claims that are at stake for an organization, it is also the greater risk of being out of compliance with CMS regulations that could lead to sanctions, fines, corporate integrity agreements, etc. The CEO and GB are responsible for the financial health of the organization as well as for implementing an effective compliance program.

The CEO, as a part of the compliance program, must educate the GB on the False Claims Act (FCA) because, even if incorrect bills are unintentional, the FCA may still apply. Following are excerpts from the FCA from CMS' website:

For purposes of this section [of the False Claims Act], the terms 'knowing' and 'knowingly' mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. "While the False Claims Act imposes liability only when the claimant acts 'knowingly,' it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable.[1]

Although the CEO will not directly manage the RAC work, only the GB and CEO can prioritize RAC and billing compliance and provide the resources required to meet the obligations of the government. When allocating resources, the CEO has the advantage of a global perspective. It is critical to involve high levels of the entire leadership team because compliant billing will involve all aspects of the organization including the medical staff. Only leadership can effectively drive change and knock down silos.

Even as we write this book, the RAC program continues to change and evolve, and although there are many resources available for individual and code-level issues related to RAC (the micro level), we will focus on a macro, systemic approach to RAC readiness to build a compliant organization that communicates effectively and strives for continual improvement. We wish to demonstrate how all parts of the organization fit together for billing compliance while providing the tools to approach and respond to individual audits.

An Ounce of Prevention Is Worth a Pound of Cure

For those of us with many years of hospital experience, we know that every decade or so, we are faced with new rules that require a significant retooling of our systems in order for our hospitals to adapt and thrive. Think of the adaptations we made to be successful with diagnosis-related groups (DRG), then Medicare severity DRGs, evidence-based medicine, and continuous survey readiness with tracer methodology. Now we have expanded postbilling Medicare audits with serious compliance and financial consequences if errors are found.

The RAC program is not a one-time audit of hospitals; it is a permanent program across the United States. RACs will soon be expanding to physicians offices, and CMS will soon roll out its equivalent

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1. Source: CMS. False Claims Act (FCA) excerpt. (n.d.). Retrieved November 25, 2010, from *www.cms.gov/smdl/downloads/SMD032207Att2.pdf.*

program for Medicaid. This is in addition to the Medicaid Integrity Program, in which CMS has contracted with Medicaid integrity contractors much the way they have contracted with RACs. CMS initially required that states fully implement a RAC program by April 2011, but in a bulletin issued in February 2011, CMS indicated that the deadline has been extended. The new deadline is expected to be published by CMS sometime this year.[2]

After successfully navigating the RAC demonstration project in South Carolina and carefully studying the changes that were made to the program, we have designed this book as a toolkit that we hope will give you a framework with which to successfully approach the RAC process and minimize recoupments by CMS. Because there are so many variables involved across every organization, we cannot guarantee individual hospital results.

> Critical to approaching RAC or other audit programs is to be proactive in creating and maintaining a compliant organization rather than waiting until an audit to do something. As you read this book, two themes regarding compliance will stand out:
>
> The CEO, hand-in-hand with the GB, must understand and drive the process from the top.
> Each facility needs the right structure, process, and people to manage the operations function of billing compliance.

By continually self-regulating its own compliance, the organization is far less vulnerable to RAC over-payment recoupments or other potentially serious compliance problems. Although we focus on RAC and billing compliance, the systems contained herein can be the foundation for dealing with an ever-changing billing regulatory environment and third-party payers that quickly follow CMS' lead when it comes to billing and payments.

To be successful, approach RAC as you would any significant performance improvement (PI) project. With planning, the right systems and good audit tools can prepare you for a RAC audit before you receive a RAC's request for records. Too many facilities are taking a "wait and see" approach without assessing

2. Source: Budetti, P., & Mann, C. CPI – *CMCS Informational Bulletin*; Clarification of CMS expectations for state implementation of Medicaid recovery audit contractor (RAC) programs. (February 2, 2011). Retrieved March 6, 2011, from *www.nebmed.org/uploadedFiles/RAC%20delay.pdf.*

and quantifying their own risk. By doing so, they are setting the organization up for failure upon appeal, if they have the ability to appeal at all.

> All providers, regardless of size, should operate as if they will soon receive a request for records from their RAC. Because the RACs are set up as permanent entities and because there is not a limit to the number of audits and providers they review, their growth potential is huge.

Unfortunately, once you receive a postaudit demand letter claiming overpayments were made, there are only two possible outcomes for each claim:

1. Your documentation and coding will support the billing claims.

2. Your documentation and coding will not support the billing claim.

If you find your facility cannot support the billing claim with existing documentation, all you can do is refund the overpayments to CMS and implement a PI process to correct errors so as to be compliant with CMS billing in the future. If, however, your documentation supports the billing claims, you have a legitimate reason to appeal any RAC claims of overpayment. One thing is certain: RAC and similar audits are here to stay; therefore, you must have a permanent system of billing compliance improvement in place.

Billing might be the most complicated, nonclinical system in our hospitals because multiple functions must be performed correctly over many diverse departments and locations. In addition, some of the functions under billing often feel as if they are out of our control, such as physician documentation. Other functions are directly out of our control, such as the ever-changing regulatory environment. The RAC program adds a level of scrutiny to billing compliance that requires understanding and cooperation between functional areas and departments in a far more direct approach than ever undertaken previously. It demands knowledge and engagement of frontline staff and physicians regarding billing issues they may see as outside the scope of their job. In fact, physicians may actively reject involvement; buy-in from the medical staff will take time and persistence.

Because a RAC is identifying errors in your systems, the initial RAC work on your part should include flow-charting a patient from admission to discharge to identify all aspects of billing, especially appropriate clinical documentation and points of opportunity for billing errors. Start with the physician offices and admission orders and continue through coding and final billing. We think of this process as billing "tracer methodology" or Healthcare Failure Mode and Effect Analysis used for continuous survey readiness. As stated previously, use your knowledge and the systems of improvement you already have in place to prepare for RAC.

This book provides a more detailed description of resource allocation to front-end prevention versus the back-end processes of error correction. This will ultimately result in fewer resources needed to correct errors and a reduction in vulnerability to RAC audits.

Because of the enterprisewide scope needed to maintain billing compliance, we advise you not to relegate your RAC-preparedness program to the finance and the revenue cycle teams alone. Although finance and revenue cycle personnel have important roles to play, RAC and postbilling audits are critical issues for the entire executive team because of the magnitude of risk and complexity of compliant billing.

Success requires leadership and priority setting from the CEO and solid operation performance from staff. Only the CEO can eliminate turf wars and push back that which may otherwise endanger success. The CEO must recognize the importance of RAC and place resources where they are needed.

Reading This Book

This book is designed to walk you through RAC preparedness and response by doing the following:

1. Introduce the RAC program (Chapter 1)

2. Begin a discussion on RAC preparedness (Chapter 2)

3. Detail a suggested RAC-ready organizational structure through committees (Chapter 3) and key personnel (Chapter 4)

4. Discuss the RAC impact on key stakeholders in your organization (Chapter 5)

5. Provide detail on the two types of RAC reviews (Chapters 6 and 7)

6. Detail the appeals process (Chapter 8)

If you picked up this book because you just received a request for records or a demand letter and you need to know what to do and how to do it, you can skip to the RAC committee section in Chapter 3 and turn to the chapters focused more on RAC response than RAC preparedness, which are Chapters 6 through 8.

Even if you skip to the appeals section just to get through the first RAC audit, we hope you will look to the rest of the book to help you restructure your organization to prepare for future audits. If you are constantly in "response" mode as opposed to "preparedness," you are setting yourself up for a long road of multiple audits for the same issues.

Keep in mind that CMS may, along the way, change some of the rules and requirements of the program (e.g., documentation limits, deadlines, submission guidelines), so it is essential that you keep up to date with any changes to the program. Throughout the book, we provide suggestions, websites, contact information, and resources to help you more easily stay current on the programmatic changes.

> As with any healthcare book, we will use many acronyms. Appendix A *(www.hcpro.com/ downloads/9518)* provides a list of acronyms used in this book. Throughout this book, the acronym "RAC" refers both to the Recovery Audit Contractors that have been engaged by CMS to perform RAC audits and to the *process* of RAC itself. Using RAC to refer not only to the contractors but also to the entire process has become common across the industry in articles and other forums.

DOWNLOAD YOUR MATERIALS NOW

Along with Appendices A–E referenced throughout this book, you can download the following forms and tools at the URL provided below:

Figure 1.4: RAC Appeal Timeline

Figure 2.1: RAC Systems Preparedness Checklist

Figure 3.1: RAC Committee Structure

Figure 3.2: Minutes Template

Figure 3.5: Ongoing Work of Care Management and RAC Committee Oversight

Figure 3.6: Sample Agenda for RAC Committee Meeting

Figure 3.9: RAC Readiness PI Methodology

Figure 3.10: Sample Agenda for UR Committee

Figure 4.2: ACM Audit Tool for Admission Review

Figure 4.4: Admission, Continued Stay, and Discharge Review Flowchart

Figure 5.2: Patient Status Change to Outpatient Notification Letter

Figure 6.1: Automated Review Timeline

Figure 7.1: Complex Review Timeline

Figure 8.5: Sample Appeal Letter for Appeal Level 1: Redetermination

CMS Form 20027 Medicare Redetermination Request Form—Appeal Level 1

CMS Form 20033 Medicare Reconsideration Request Form—Appeal Level 2

CMS Form 20034 Request for Medicare Hearing by an ALJ—Appeal Level 3

CMS Form DAB101 Request for Review of ALJ Medicare Decision/Dismissal—Appeal Level 4

Website available upon the purchase of this book.

Thank you for purchasing this product!

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1

RAC Program Overview

As stated by the Centers for Medicare & Medicaid Services (CMS), the mission of the RAC program is to find and correct previous improper payments and to implement changes that will prevent improper payments in the future. CMS has contracted with RACs to help them achieve their mission and has given RACs the power to audit Medicare claims for a quickly growing list of issues across multiple provider types to recover these improper payments.

> Although this book will focus primarily on acute care facilities, the rules, timelines, and approach remain much the same across other provider types. Occasionally, we will provide additional detail on how the program differs between provider types.

As you are probably aware, CMS and other payers are not the only groups scrutinizing how hospital bills are paid. The public is becoming increasingly aware of Medicare costs and how the government is attempting to reduce those costs. Taxpayers want to ensure that Medicare costs are minimized, and Medicare recipients want assurances that benefits will not change or will possibly even improve. CMS has started a public awareness campaign that includes a focus on Medicare fraud and recoupments.

In a 2010 advertisement, Andy Griffith touts the benefits of the "new healthcare law." In it, he says that 2011 will bring Medicare participants "better ways to protect us and Medicare from fraud," while "Billions Recovered So Far" flashes at the bottom of the screen.[1] This seems to refer directly to the recoupments from the RAC demonstration project, in which RACs made approximately one

1. Source: CMS. "1965 Music to My Ears." (n.d.). Retrieved November 25, 2010, from *www.youtube.com/watch?v=SbqwT3lJdnA*

billion in overpayment claims. Clearly, from a marketing perspective, CMS is applying the word "fraud" to coding and documentation errors, not just bold "gaming" of the system.

Although we focus on the RAC program in this book, the overarching issue is billing compliance. The Patient Protection and Affordable Care Act (PPACA) will broaden compliance program requirements and self-reporting requirements (60 days for reporting internal findings) for providers and expand RAC into Medicaid, Medicare Advantage, and Part D (drug benefits). Links to an article on the PPACA and to the current compliance program requirements issued by the Office of Inspector General (OIG) follow. We expect new guidelines for compliance will be issued as the focus on Medicare fraud and abuse expands with increased penalties.

- HealthcareReform.gov, "The Affordable Care Act: New tools to fight fraud, strengthen Medicare and protect taxpayer dollars": *www.healthreform.gov/affordablecareact_summary.html*

- OIG, "Compliance guidance": *http://oig.hhs.gov/fraud/complianceguidance.asp*

What Are RACs and What Do They Do?

Throughout the book, we will frequently refer to the RAC section of CMS' website (*www.cms. hhs.gov/RAC*), where you can find updates to the program. We have noticed, even at this relatively early stage of the program, that some documentation on this site is outdated and some links are invalid, so please be sure you first go to the "Recent Update" section of the site, which should have the most current information. You can also contact CMS or the RAC assigned to your region by e-mail or by phone with questions or for clarification of an issue. Appendix B lists CMS links and contact information. CMS recommends you go to your RAC for information first.

CMS has contracted with the following four RACs—each assigned to a different region of the United States:

- Diversified Collection Services (DCS)—Region A

- CGI—Region B

- Connolly, Inc.—Region C

- HealthDataInsights, Inc.—Region D

The following map shows which states are assigned to each RAC (**Figure 1.1**). The shading in the map indicates when RACs can e-mail audit request letters to providers. Notice that all the dates have passed, so no matter where your organization is located, you could receive an e-mail or letter requesting records at any time, and depending on how many campuses you have in your organization, you may receive multiple requests from a single or from multiple RACs. You will receive a records request only for cases to be reviewed under the complex audits. For automated audits, there will be no

Figure 1.1	CMS Map Showing Contractor Regions

March 1, 2009

March 1, 2009

August 1, 2009 or later

Source: CMS. Map of future RAC jurisdictions. (n.d.). Retrieved October 1, 2010, from www.cms.gov/RAC/downloads/Four%20RAC%20Jurisdictions.pdf *(link no longer active).*
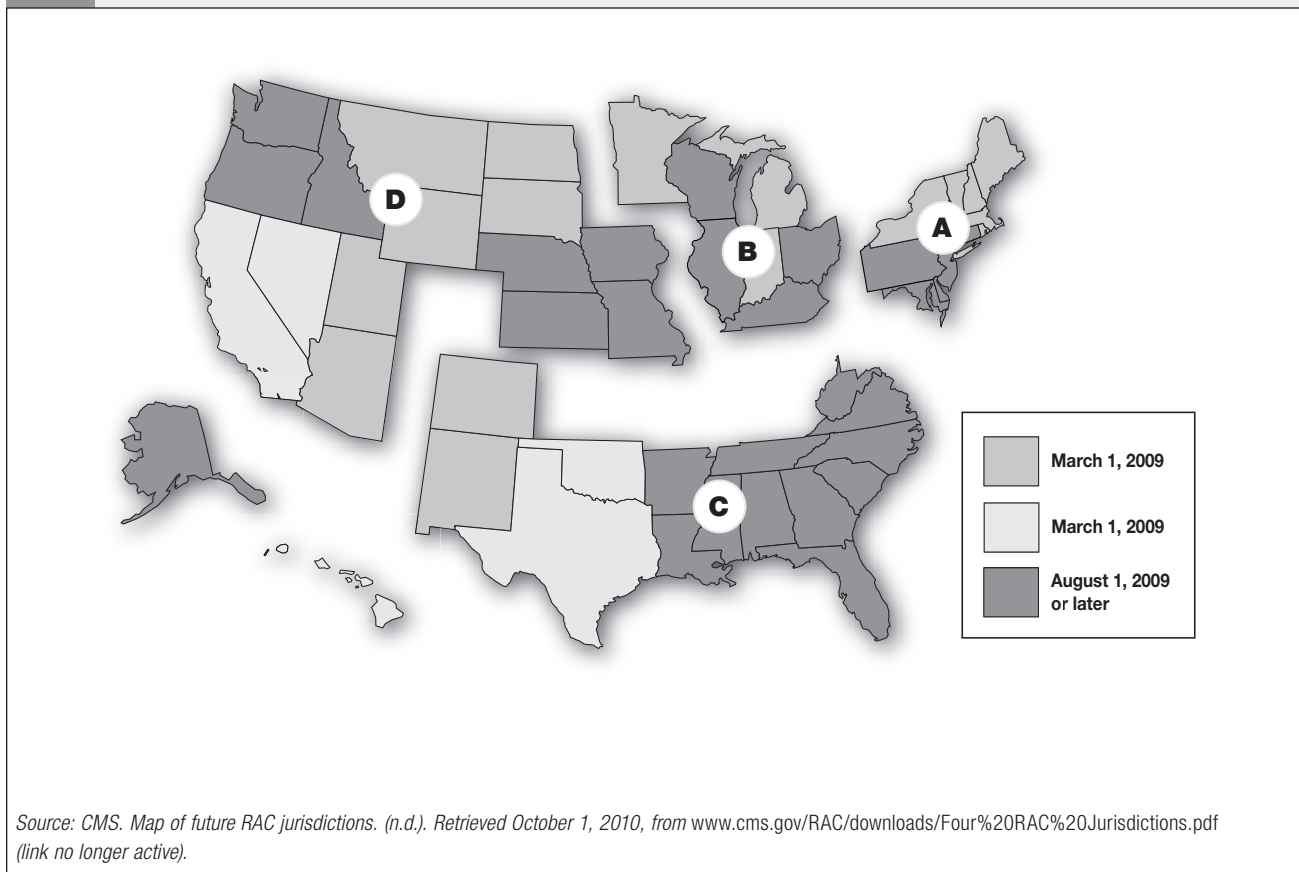
request for records, and you will not know which cases were reviewed unless you receive a demand letter. Any claims of improper payments will be made in this letter. In fact, you will not be notified at all of automated cases that were reviewed but that passed tests for improper payments. The definition of *campuses* will be described later in this chapter, and we will take a more comprehensive look at the automated and complex audits in Chapters 6 and 7.

CMS has also approved the following subcontractors to assist the RACs with complex reviews:

• PRGX Global, Inc., (formerly PRG-Schultz, Inc.) as a subcontractor in Regions A, B, and D

• Viant Payment Systems, Inc., as a subcontractor in Region C

To ensure accuracy of the RAC process, CMS added a RAC Validation Contractor (RVC) in the demonstration project because of concerns that the RACs may not interpret CMS rules properly. During the demonstration project, the RVC was AdvanceMed Corporation, an affiliate of Computer Sciences Corporation, but in October 2008, CMS announced that the RVC would be Provider Resources, Inc. According to the "Recent Updates" section of the CMS RAC website,[2] the RVC "will work with CMS and the RACs to approve new issues the RACs want to pursue for improper payments, as well as perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments."

According to CMS, the keys to success of the program are that the provider burden is minimized, accuracy is ensured, and transparency is maximized. Some examples of minimized provider burden are that only approved issues can be audited, records can be scanned rather than sent as hardcopy, and the number of medical records requested is limited. However, the RACs will be able to look back, up to three years prior to a claim being paid, and may request additional records through CMS for audited claims.

2. Source: CMS. RAC recent updates. Retrieved November 27, 2010, from *www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage*

For additional detail of what the RACs can and cannot do, you can download the lengthy "Statement of Work for the Recovery Audit Contractors" from the CMS website.[3] In it, the RACs are tasked with identifying "vulnerability issues"—the issues on which they can base a claim of over- or underpayment—then CMS, with the help of the RVC, will decide whether to approve these issues. Although each RAC has its own issues list, you can be sure that individual RACs are closely monitoring the issues approved for other RACs and will explore these issues for their own audits.

> If you have examples of a RAC not meeting the requirements set by CMS, keep track of them and consider reporting them to CMS or to your local hospital association. Examples may be missed deadlines on the part of the RAC, incorrect information on the online claim status tool, request for records previously audited by other governmental body for same issue, failure to supply reviewer credentials if requested, etc. Unfortunately, even if these "contractual obligations" are not met, you may still be liable for the denial (more on this later).

One way issues will be added will be through sophisticated data mining to identify outliers across several types of organizations. If outliers or suspect claims are found in the data-mining process, RACs may perform "probe audits" of up to 10 cases from a provider to further identify whether problems exist and to develop a case for the issue. Record requests for these probe audits (or "test claims") do not count toward the record request limits set by CMS for individual providers, but no additional records can be requested related to a specific issue until after the issue is approved by CMS.[4]

To explain further, the "issues" are any areas where CMS, the RVC, and the RAC believe there is a vulnerability that allows for improper payments. Although RACs are charged with identifying over- and underpayments, only a very small portion of the issues will likely identify and address underpayments. In fact, in the demonstration project, only 4% of identified improper payments were

3. Source: CMS. Statement of work for the Recovery Audit Contractor program. (n.d.). Retrieved November 27, 2010, from *www.cms.gov/rac/ downloads/Final%20RAC%20SOW.pdf.*

4. Other sources indicate that the 10 test claims do count toward additional documentation request (ADR) limits, but we confirmed in a telephone call to DCS customer service on December 21, 2010 (phone number: 866/201-0580), that these test cases remain a separate documentation request and no not apply to the facility's ADR limit unless, after the issue is approved, all or some of these records are included in the complex audit review, but the RAC will indicate such in the request letter.

underpayments (see **Figure 1.2**). For the most part, this is because the process lends itself to finding postclaim errors, which are usually overpayment-related. Underpayments are more often a result of not capturing charges or of "undercoding," which would not necessarily be identified in the postclaim documentation.

To maximize transparency of the program and keep providers up-to-date, CMS suggests visiting the website of their assigned RAC to find this information.[5] It is critical that your organization stay updated on the issues and major findings so that you can adjust your estimates of the risk of recoupments as new issues are added or modified. We will discuss assessing your risk of recoupments in Chapter 2.

Unfortunately, keeping abreast of all RAC issues for your region is not as easy as going to your RAC's website and pulling out the newly posted issues. Existing issues can be changed at any time with no notification. Changes to previously posted audits include added Medicare severity diagnosis-related groups (MS-DRG) reviewed, alterations to the list of states affected, links to additional information, and removal of medically necessity exclusions for specific MS-DRGs. At least one of the RACs does not include a posted or approved date and most do not specify whether the issue is for automated or complex review. *Healthcare Finance News* reported that on January 14, 2011, Connolly posted 77 new issues, which added 216 MS-DRGs to the list for DRG validation and 70 MS-DRGs to the list for medical necessity review.[6]

Some organizations, including ours, are attempting to track the issues lists in a single, searchable spreadsheet, database, or application. We use our database as part of our risk assessment software that helps organizations identify cases that could be impacted by automated or complex reviews. (Risk assessment will be discussed further in Chapter 2.) A database of issues would also allow you to search, sort, group, e-mail, and print issues—functionality that is not available across the RAC websites.

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5. Source: CMS. *Medicare Quarterly Provider Compliance Newsletter,* vol. 1, issue 1. (2010). Retrieved November 27, 2010, from *www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf.*

6. Source: De Los Santos, E. "RACs Post Many New Issues." (2011). Retrieved January 23, 2011, from *www.healthcarefinancenews.com/ blog/racs-post-many-new-issues.*

Figure 1.2	Overpayments vs. Underpayments From Demonstration Project

Overpayments Collected
96%

Underpayments Repaid
4%
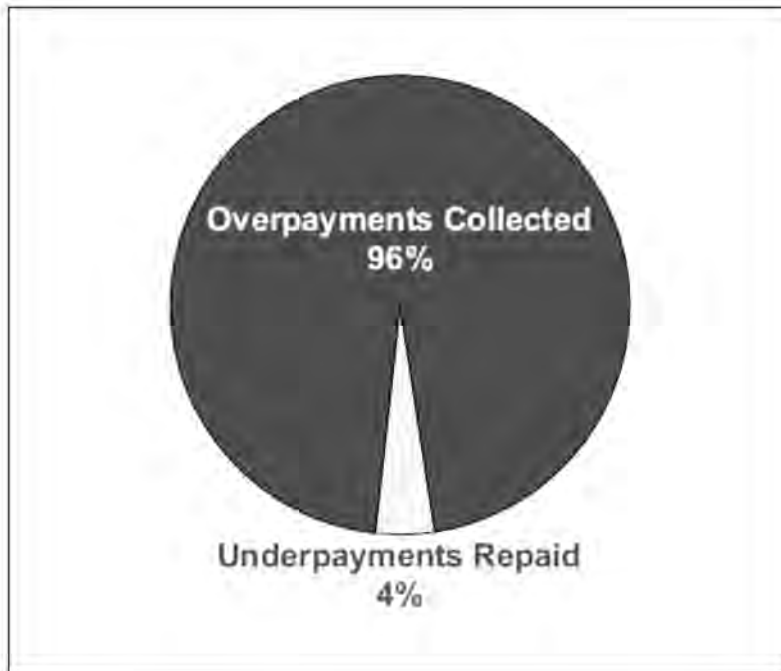
Table 4. Improper Payments Corrected by the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs
(Million Dollars)

RAC	Overpayments Collected[a]	Underpayments Repaid[b]	Total Improper Payments Corrected
Connolly	$ 266.1	$ 4.3	$ 270.4
HDI	$ 396.1	$ 20.8	$ 416.9
PRG	$ 317.8	$ 12.7	$ 330.5
Claim RAC Subtotal	*$ 980.0*	*$ 37.8*	*$ 1,017.8*
HMS	$ 1.3	$ 0.0	$ 1.3
DCS	$ 11.4	$ 0.0	$ 11.4
MSP RAC Subtotal	*$ 12.7*	*$ 0.0*	*$ 12.7*
Grand Total	$ 992.7	$ 37.8	$ 1,030.5

[a]Collected is defined as overpayments that have been recovered from providers and deposited.
[b]Repaid is defined as underpayments that have been paid back to the provider. MSP RACs were not tasked with identifying underpayments.
Note: For this Evaluation Report, CMS lists all dollars actually collected and repaid between March 2005 and March 2008. In contrast, reporting for the FY 2006 RAC Status Document was based on overpayment and underpayment *notification letters* that were sent to providers and to the Medicare claims processing contractor during the fiscal year.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Source: CMS. The Medicare Recovery Audit Contractor (RAC) program: An evaluation of the 3-year demonstration. (2008). Retrieved November 27, 2010, from www.cms.gov/RAC/Downloads/RACEvaluationReport.pdf, *p. 15.*

You can find links to each RAC's list of issues, along with contact information, in Appendix B *(www.hcpro.com/downloads/9518).* Although CMS initially indicated that it would list issues and significant findings on its website, it has not done so as of the writing of this book and recommends that providers review the issues lists on their assigned RAC's website. Similarly, in this book, we will not address specific vulnerability issues (except as part of case studies) but will provide you with the tools you need (in the form of organizational structure, process, and people) to mitigate your risk by creating a more transparent, compliant organization.[7] Within this framework, it will be the RAC committee (to be discussed in Chapter 3) that keeps track of approved issues and how these issues may be applied in an audit of your organization.

> Before reading further, you may want to take a moment to visit your RAC's website to familiarize yourself with the functionality of the website, or lack thereof.

Despite not having approved issues listed on its RAC website, CMS has started to publish *Medicare Quarterly Provider Compliance Newsletter,* with the first issue, released in October 2010, highlighting eight issues across different provider types.[8] The newsletter indicates that the issues listed in it are identified by CMS and its contractors, such as RACs, but does not specifically state that they are approved issues for all RACs. CMS will highlight other issues of noncompliance in future newsletters.

> Reimbursement to critical access hospitals (CAH) is cost-based, not fee schedule–based, so the RACs will focus on overutilization of resources and may spend time reviewing the cost reports for CAHs.

RAC audits are retrospective—the case has already taken place, the bill has been dropped, and (in most cases) paid before the RAC audit occurs. RACs are looking for cases where the documentation does not support the payment that was already made.

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7. Chapters 5 and 6 of Kimberly Anderwood Hoy's book, *The RAC Survival Guide*, does discuss some (but not all) specific RAC target areas. That excerpt is available at *www.hcpro.com/downloads/9518.*

8. Source: CMS. *Medicare Quarterly Provider Compliance* Newsletter, vol. 1, issue 1. (2010). Retrieved November 27, 2010, from *www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf.*

RACs have staff similar to that of the fiscal intermediaries (FI) and Medicare administrative contractors (MAC) in that they are required to employ nurses, certified coders, therapists, and a contractor medical director.[9] You can even request the credentials of the individuals who reviewed your documentation and made a claim of overpayment. The RACs are paid on a contingency-fee basis, meaning they get a percentage of any improper payment (including underpayments); however, in an effort to ensure accuracy, the RACs must pay back the contingency fee if the provider appeal is won at any level. Each RAC has negotiated a different percentage of improper payments as its fee, as follows:

- Region A, DCS: 12.45%

- Region B, CGI: 12.50%

- Region C, Connolly, Inc.: 9.0%

- Region D, HealthDataInsights, Inc.: 9.49%

It is interesting that the OIG and the General Accounting Office (GAO) seemingly frown on providers and states hiring consultants on a contingency basis to review Medicare claims and organizational processes to identify underpayments because of the temptation for the consultants to encourage upcoding and other (potentially) noncompliant practices. In a 2001 *Special Advisory Bulletin*, the OIG advised providers to be wary of consultants who make promises to increase Medicare payments, indicating that they would do so because fees are "often based on a percentage of this increased reimbursement."[10] In a 2005 report to the Senate Finance Committee, the GAO advised that CMS track states' use of contingency-fee consultants to improve Medicare reimbursement, stating that there was "long-standing recognition that such claims are at risk of being inconsistent with federal requirements."[11] CMS subsequently indicated that it did not have the authority to require that states disclose their use of these consultants, but stated in its response, "We do not dismiss the notion that

9. Medicare uses the acronym CMD when referring to the contractor medical director, but in this book, CMD refers to the hospital care management director, who is critical to the RAC process and whose role will be discussed in later chapters.

10. Source: OIG. *Special Advisory Bulletin: Practices of business consultants.* (n.d.). Retrieved November 27, 2010, from *http://oig.hhs.gov/fraud/docs/alertsandbulletins/consultants.pdf*, p. 4.

11. Source: Cosgrove, J. C. Medicaid financing: States' use of contingency-fee consultants to maximize federal reimbursements highlights need for improved federal oversight. Retrieved November 27, 2010, from *www.gao.gov/new.items/d05748.pdf.*

the involvement of contingency-fee based consultants (CFCs) in generating Medicare claims may be a factor in assessing risk."[12]

The RACs review paid claims using the same Medicare rules and policies used by the FIs and MACs. Hospitals must also structure their billing compliance programs on these same rules; however, the difficulty lies in the interpretation and application of the rules by each of the three parties: FIs/MACs, RACs, and providers. Guidance on the rules can be gleaned from several sources such as the *Federal Register*, CMS manuals, national and local coverage decisions, CMS educational forums, and guidance from FIs or MACs. Because guidance can come from several sources, keep copies of all guidance used to create billing compliance policies or to determine validity of a specific claim or set of claims. If guidance is in the form of a website, save or print out the webpage because it may not be available online later. If the guidance is in the form of webinar, educational session, or phone call with CMS or an FI or MAC, keep notes detailing what was discussed. These documents and supporting notes can be submitted with the appeal as additional supporting documentation for a denied claim, although there is no guarantee they will be effective.

A Quick Note About MACs

As required by the 2003 Medicare Prescription Drug, Improvement, and Modernization Act, all providers will transition from FIs and Medicare carrier contracts to MACs between 2005 and 2011. As with the RAC program, CMS has created MAC regions (termed *MAC Jurisdictions*) that will allow for Medicare A and B to fall under one contractor for providers in each region.[13] This may be step one in CMS' preparation for bundling of charges and accountable care organizations. As the PPACA broadens the RAC to Medicaid, Medicare Advantage, and Part D, it is logical to expect the MACs to align with RAC regions for all provider types.

There are different MAC jurisdictions for different types of providers (see **Figure 1.3**). The majority of providers (Part A and Part B) are covered by 15 different A/B MAC jurisdictions, but there are

12. Source: Cosgrove, J. C. Medicaid financing: States' use of contingency-fee consultants to maximize federal reimbursements highlights need for improved federal oversight. Retrieved November 27, 2010, from *www.gao.gov/new.items/d05748.pdf*, p. 58.

13. Source: CMS. Vision of future fee-for-service Medicare environment. (n.d.). Retrieved November 27, 2010, from *www.cms.gov/MedicareContractingReform/04_VisionofFutureFeeforServiceMedicareEnvironment.asp#TopOfPage*.

Figure 1.3 — MAC Jurisdictions Maps

Durable Medical Equipment Medicare Administrative Contractor Jurisdictions
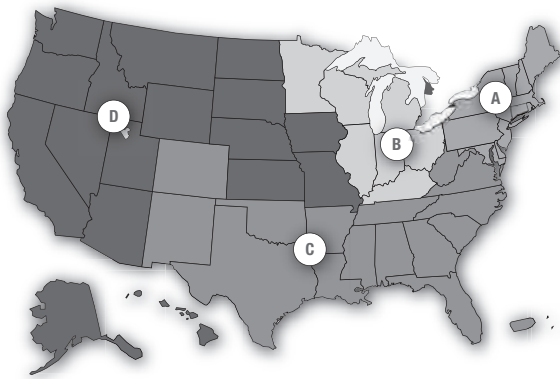
Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)

A — National Heritage Insurance Company
D — Noridian Administrative Services
B — CIGNA Government Services
C — Palmetto Government Benefits Administrator

A/B MAC Jurisdictions
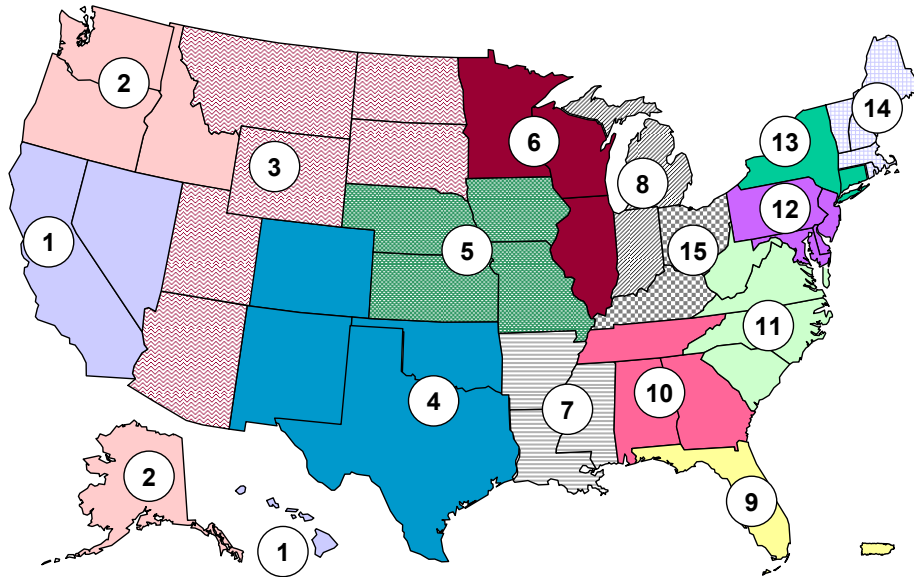
Source: CMS. DME MAC jurisdiction map. Retrieved November 27, 2010, from www.cms.gov/MedicareContractingReform/Downloads/Specialty_MAC_Jurisdiction_MAP.pdf.

Source: CMS. HH & H MAC jurisdiction map. Retrieved November 27, 2010, from www.cms.gov/MedicareContractingReform/Downloads/HHMACMAP.pdf.

Source: CMS. A/B MAC jurisdiction map. Retrieved November 27, 2010, from www.cms.gov/MedicareContractingReform/Downloads/Primary_AB_MAC_Jurisdictions_MAP.pdf.

separate jurisdiction maps for other specialty providers. MACs for durable medical equipment (DME) suppliers cover the same four regions as the RACs. Home health and hospice MACs also have four jurisdictions, but they are not the same as the RACs. For more information on MACs, visit CMS' Medicare Contracting Reform website, *www.cms.gov/MedicareContractingReform/.*[14]

RAC Audits and Appeals Overview

RACs will perform two types of audits that can lead to a claim of improper payment: automated reviews and complex reviews. As the names suggest, in an automated review, RACs use software to mine claims for errors; in complex reviews, RACs request to examine individual medical records. In a complex review, you will receive a letter requesting specific documentation, but in an automated review, you will not know when and which cases are being reviewed. After a complex audit, the RAC is required to send a review results letter outlining the findings of all claims reviewed, including those that show no overpayment or underpayments. There is no results letter for an automated review.

With both reviews, RACs may be able to use extrapolated error rates to calculate overpayments across multiple cases, and they may examine multiple claims, from multiple providers, for a single clinical episode. Each type of review will be discussed in Chapters 6 and 7, including a discussion of how extrapolation works and its potential impact on outpatient cases.

If an underpayment is found, the FI or MAC will transfer the balance to the provider. If there is a claim of overpayment, in both automated and complex reviews a demand letter is issued outlining the claim of overpayment, which starts the clock on the rebuttal, recoupment, and appeals process. For each claim of overpayment, providers will need to decide whether to appeal and how far to take each appeal. There are five levels of appeal, with review by a separate body at each level. We will discuss how to assess and navigate the appeals process in more detail in Chapter 8, but as an introduction, the appeals timeline and process is shown in **Figure 1.4**.

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14. Source: CMS. Overview. (n.d.). Retrieved November 27, 2010, from *www.cms.gov/MedicareContractingReform/ 04_VisionofFutureFeeforServiceMedicareEnvironment.asp#TopOfPage.*

Figure 1.4 — RAC Appeal Timeline
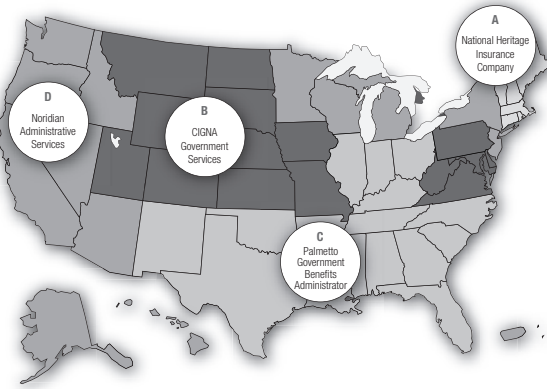
Appeal Level	Days to appeal	Days to render decision
I. Redetermination	120	60
II. Reconsideration by Qualified Independent Contractor (QIC)	180	60
III. Administrative Law Judge (ALJ)	60	90
IV. Appeals Council Review	60	90
V. Judicial Review	60	Not specified
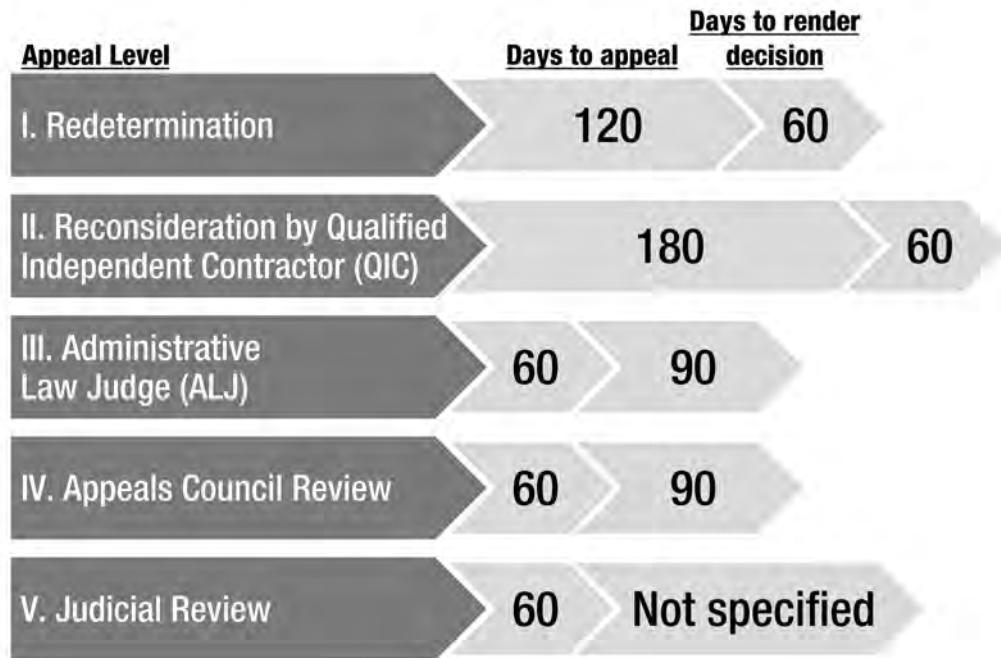
During the first level of appeal (redetermination), there is a concurrent discussion period and a few milestones that occur after the receipt of the demand letter (Day 0):

1. Day 15: This is the deadline for the rebuttal statement in which the provider claims that recoupment should not take place because it will cause a financial hardship—the RAC may or may not continue with recoupment after review of the rebuttal statement.

2. Day 30: If appeal is received by this deadline, recoupment will not take place automatically on day 41 (however, providers may want to make a payment on this day to avoid interest if appeal is unsuccessful). For payments after this date, interest will be due and will be calculated from the day of receipt of the demand letter.

3. Day 40:[15] This is the end of the discussion period, which allowed for discussion of the claim with the RAC medical director. New information may be submitted during this period, and it may or may not result in reversal of the claim. It is not the formal appeal.

4. Day 41: This is when automatic recoupment happens, unless the appeal was received on day 30, the discussion resulted in overturning of the denial, or the rebuttal statement was successful in stopping recoupment until after appeal takes place.

5. Day 120: Appeal due.

The request for redetermination is reviewed by the RAC, but by a different individual than who originally made the claim of overpayment. Each subsequent level of appeal is reviewed by a different body (see Figure 1.4) and, not surprisingly, costs increase for the provider with each level of appeal. However, once the work is done for decision to appeal and the appeal documents are complete for Level 1 appeal, they can be used for all levels of appeal. After appealing at Level 1, there should be little additional cost through Level 3 unless testimony is required. Additional cost is incurred, however, at Levels 4 and 5, where outside resources like lawyers or consultants are needed.

After the second level of appeal, there may be timeline extensions if the reviewing body returns to the provider with a request for more information, or if other delays are granted to ensure due process. Although the facility may provide additional documentation at the early levels of appeal, the first appeal letter submitted should be complete and stand on its own, even at third level of appeal. Documentation in the chart cannot be changed; only additional notes or other documentation such as therapy notes can be submitted.

Changes Based on the Demonstration Project

Much of the advice in this book is based on what we learned preparing for and navigating RAC, as we experienced the process firsthand during the demonstration project. The demonstration project was the initial, three-year trial review that ran from 2005 to 2007 and involved six states: initially

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15. In the case of the complex review, the discussion period actually starts with the receipt of the results letter rather than receipt of the demand letter.

California, Florida, and New York, with South Carolina, Massachusetts, and Arizona added in 2007. Just as we gleaned some valuable lessons learned from the experience, CMS made several changes to improve the program, as shown in **Figure 1.5**.

Figure 1.5
Changes from Demonstration Project

Issue	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date – date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP included	Yes	No
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
RAC claim status Web page	Not Required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

Source: CMS. The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration. (2008). Retrieved November 27, 2010, from www.cms.gov/RAC/Downloads/RACEvaluationReport.pdf.

One of the major changes was the discontinuation of the Medicare Secondary Payer (MSP) RAC program. In the demonstration project, the three MSP RACs (as opposed to the claim RACs) were tasked with identifying claims in which Medicare paid the primary portion of a claim while the beneficiary had insurance coverage with a carrier that should have been identified as the primary payer. As you may have noticed in Figure 1.2, the MSP RACs collected significantly fewer overpayments than the claim RACs, who were charged with identifying improper payments. For this and other reasons, CMS decided to discontinue the MSP RAC program while allowing the claim RACs to identify MSP occurrences.[16] However, according to the CMS RAC Statement of Work, if a RAC finds a claim with an MSP occurrence that results in denial of the claim, the RAC does not get any credit (or compensation) for that denial.[17]

Another interesting change is that the RAC medical director must be available to discuss a claim during the discussion period. Considering the volume of audits and appeals, it will be interesting to see how the RACs will ensure that this occurs and that the discussions take place in a timely manner.

Track Your RAC Activity and Stay Up to Date With Changes and Advice

After the discussion project, the RACs were required to implement web-based claim status tools for providers. The claim status webpages can be accessed through each RAC's main website and should allow providers to review what complex reviews are taking place, what documentation has been requested and received, when documentation is due to the RAC, and when responses are due by the RAC to the provider. Although you should use the claim status tool to ensure that the RAC has received the documentation you sent and to check on progress of your claims, you should also track your RAC activity in your own tracking database. There are several providers of software that will help you track each claim from audit through appeals so nothing falls through the cracks. Your tracking software, whether home-grown, off-the-shelf, or specially developed for your organization, should track documentation submission, remind you of submission and appeal deadlines, and allow

16. CMS. The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration. (2008). Retrieved November 27, 2010, from *www.cms.gov/RAC/Downloads/RACEvaluationReport.pdf.*

17. CMS. Statement of work for the Recovery Audit Contractor program. (n.d.). Retrieved November 27, 2010, from *www.cms.gov/rac/downloads/Final%20RAC%20SOW.pdf.*

you to assign issues and accountability for specific RAC-related tasks. Although tracking should start with the request letter for complex reviews, because it becomes most critical during the appeals process, we will provide more information on tracking in Chapter 8.

Many of the changes instituted after the demonstration project stem from the difficulties experienced in managing the complex reviews, not just for the providers, but ultimately for the RAC auditors as well. We expect that, as the RAC program is rolled out to more facilities, there will be further changes. Continue to visit CMS' RAC website (especially the "Recent Update" link) and the website of your region's RAC for updates to the program as well as additions to the issues list. It is also important to visit the websites for other RACs because once one RAC takes up an approved issue, the other RACs will likely follow suit, although they still have to individually gain approval for the issue from CMS. In addition, other RACs may post helpful information not available your RAC's website. Contact and website information is listed in Appendix B at *www.hcpro.com/downloads/9518*.

You should consider setting a schedule for checking these websites and include reminders to do so in committee or individual calendars. For example, the CEO and executive team may want to schedule a quick review of the CMS RAC "Recent Updates" website and the facility's RAC website, while the RAC committee or physician advisor, or both, may want to review all the sites every week or two.

There are also several healthcare organizations that provide updated information, articles, and advice about CMS and the RAC program on their websites or through their newsletters, webinars, etc. We have listed several, along with links, in Appendix B.