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IMA Insights

Volume 6, Issue 9 September 1, 2008

Dispelling RAC Myths

To our Healthcare Clients and Friends:

This issue of IMA Insights focuses on the many "myths" regarding Recovery Audit Contractors (RAC). The Centers for Medicare and Medicaid Services (CMS) has published various operational and status updates during the three-year RAC demonstration program to communicate results to the healthcare community. This article outlines key recent developments, dispels various myths about the RAC program, and provides unique insights for providers, as they venture into the reality of the permanent national RAC program.

Recent Developments

The RAC demonstration project, which began in March 2005 and concluded in March 2008, has resulted in more than $992 million of overpayments being collected from providers. The annual overpayments have grown significantly over that three-year time period, as only 4% occurred in FY 2006, compared to 34% in FY 2007 and 62% in the first half of FY 2008. CMS clearly views the demonstration project as a cost effective program and, unfortunately for providers, one that is a viable and useful resource for detecting and correcting past improper payments.

Since our last article that dealt with RAC issues (visit www.ima-consulting.com for previous RAC articles), there have been numerous developments, including:

- RAC has gone from a demonstration project to a permanent program
- The National Statement of Work was issued in November 2007
- CMS issued "CMS RAC Status Document- FY 2007", in February 2008, which focused on the operations and findings of the CMS RAC program
- CMS issued a report titled "The Medicare RAC Program: An Evaluation of the 3-Year Demonstration" in June 2008

The RAC program began in 2005 as a demonstration project covering three states: California, Florida, and New York. It was then expanded into Massachusetts, South Carolina, and Arizona in 2007, and will now be expanded nationwide to cover all 50 states.

Before the program was to be expanded nationally, one of CMS's main goals was to address concerns raised by the provider community. The provider community made a lot of "noise" regarding their concerns about the RAC demonstration program. Your voices have been heard, for now, as the permanent RAC program includes numerous changes, many of which are supposed to improve the process. The question that remains - are the changes good enough to correct the numerous problems with the RAC program? The following table outlines the changes made to the RAC program as stated in the CMS RAC Status Document- FY 2007 and the report titled "The Medicare RAC Program: An Evaluation of the 3-Year Demonstration".

The issues highlighted in **green** below should prove beneficial to providers. The issues highlighted in **yellow** may benefit providers but the verdict is still out, and the issue highlighted in **red** is an area of concern and may cause problems for providers.

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Issue No.	Issue Description	Demonstration Project	Permanent Program
1.	RAC Must Use Certified Coders	No	Yes
2.	Medical Record Limit	Optional, RAC-specific	Mandatory, set by CMS
3.	RAC Fee Repayment Upon Appeal Loss	Loss at First Level	Loss at Any Level
4.	External Validation Process	Optional, Vary by State	Mandatory and Uniform
5.	Quality Assurance/Internal Control Audit	No	Mandatory
6.	Standardized Notification of Provider Overpayment Letters	Not Required	Mandatory
7.	Reason for Review Listed on Request for Records and Overpayment Letters	Not Required	Mandatory
8.	Look-back Period	4 years	3 years
9.	Maximum Look-back Date	n/a	Claims paid prior to 10/1/07 not reviewable
10.	Credential of Reviewers Provided Upon Request	Not Required	Mandatory
11.	Minimum Claim Amount	$10 Aggregate Claims	$10 Minimum Claims
12.	Provider-requested Claim Denial Discussion with Medical Director	Optional	Mandatory
13.	Full Time Medical Director	No	Yes
14.	RAC Offers Web-based Application	No	Yes
15.	RAC May Review Current Fiscal Year Claims	No	Yes

Dispelling RAC Myths

Despite the fact that RAC is still a relatively new initiative, there are already numerous myths circulating around the provider community, such as:

1. **Appealing RAC findings is not worthwhile, only 4.6% get overturned**
   Considering only 14% of the claims taken back by the RAC were appealed as of late March 2008, it might surprise you to find out that, on average, 33% of the claims appealed do get overturned in the provider's favor.
2. **The Medicare RAC Program: An Evaluation of the 3-Year Demonstration document provides a list of the major RAC take-backs**
   The Medicare RAC Program: An Evaluation of the 3-Year Demonstration document only identifies a small portion of the take-backs. For example, CMS lists the top five problem areas for Inpatient Hospital, totaling $284.2 million in overpayments. However, that figure is only a small fraction of the total RAC initiated overpayments for Inpatient Hospital of $828.3 million.

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3. **The RAC always interprets the regulations correctly**
   RAC auditors may incorrectly interpret the rules and regulations that guide Medicare. Their judgments may cause charts to be reviewed or demand overpayments when there is nothing to support their judgments. Making sure that the rationale for any take-back is verified and correct is a necessary step in the RAC process. It is critical that providers challenge all reviews where the alleged errors are not clear and provide detailed responses supported by clinical documentation (read myth #1 again).
4. **Demand letters for overpayments performed through automated reviews do not need to be checked, since automated reviews do not require medical records**
   The RAC will make mistakes on all levels of reviews. Providers need to challenge all overpayment requests. Do not rely on the RAC's data mining capabilities!
5. **There is no way to know what the RAC will look at when they come**
   Providers need to familiarize themselves with the following: CMS RAC Status Document- FY 2006, CMS RAC Status Document- FY 2007, RAC Statement of Work, The Medicare RAC Program: An Evaluation of the 3-Year Demonstration in June 2008, the OIG Work plan, and as much information from knowledgeable third parties as possible (Hospital Associations, Consultants, Lawyers).
6. **RACs can request the same chart for review more than once**
   Once the RAC reviews a chart and finds no errors, they cannot reopen it. Providers should track and monitor claims falling into this category though the use of tracking software.
7. **RACs can review a claim that another reviewing agency has reopened**
   The RAC is not permitted to perform this review. If the provider discovers this error, they should send the RAC the documentation to support the original request.
8. **RACs make up their own rules**
   RACs are guided by the same Medicare policies and rules to identify improper payments as the Medicare claims processing contractors; however, their interpretation of those rules is often incorrect (again, re-read myth #1).
9. **We have a strong internal review process; we may not get a RAC letter**
   Don't forget that the RACs are paid a hefty contingency fee for their work. They are highly motivated to take back monies from everyone and since only 14% of the claims taken back actually get appealed, they may be a little too aggressive with their determinations.

It is important for providers to perform a detailed review of all available RAC-related documents to obtain an accurate view of its history and to help prepare for what is forthcoming.

Insights

RAC readiness is an extremely important task that must be given a high priority within healthcare organizations. Providers need to proactively prepare themselves for the inevitable. The following insights are some specific recommendations based on IMA Consulting's RAC experience:

1. **Form a RAC Task Force (if you haven't already)**
   Key stakeholders in all providers need to become organized and educated on RAC and focus on the best approach to defend their revenue stream. The right RAC Coordinator is a critical role to your success. This person must, first and foremost, be well respected within your organization. They should also be very knowledgeable and able to coordinate multiple healthcare disciplines towards a common goal.

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2. **Task Force Education**
   The members of your task force must be extremely knowledgeable and current on RAC issues (which continue to grow by the day).
3. **Logistical Preparations**
   Numerous preparation issues should be discussed before the RAC audits begin. These would include: consideration of use of legal counsel, medical record access challenges, tracking, and a self-assessment (either internal or external) of the medical records that may be selected during the RAC audit.
4. **Identify Likely RAC Targets**
   Be proactive and develop a sophisticated data mining approach to identifying those claims that are at risk of being reviewed by the RAC. This will not be an easy task but it is a critical part of your RAC preparedness; there are simply too many issues to take a random sampling approach.
5. **Prioritize Areas of Focus**
   Once the likely RAC targets are identified, it is important to develop a priority order plan that will help focus your efforts to those services and types of errors that are most financially significant to your organization.

Summary

The growth of the Recovery Audit Contractors (RAC) demonstration program into a permanent initiative has expanded its focus to a national level, which will result in significant increases in future CMS overpayment collections. Despite numerous changes contained within the permanent RAC program, most of which should be advantageous to providers, understanding recent developments and planning for that expansion is extremely important to the provider community. Equally important, providers need to accurately interpret what has transpired over the 3-year history of the RAC in order to proactively prepare for the future.

We are pleased to have the opportunity to provide this information to you. If you have any questions or need assistance with RAC readiness, please do not hesitate to contact either Sandy Newstein, Senior Consulting Manager at (610) 742-1424 or me at (215) 669-3988.

Yours very truly,

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