A RAC Survival Guide

Plan, track and appeal
to minimize losses

by Susan Birk
Ask healthcare finance professionals about the stark new reality that is the Recovery Audit Contract (RAC) program of the Centers for Medicare & Medicaid Services (CMS), and the words “prepare,” “track” and “appeal” come to the fore. It is safe to say that no healthcare provider welcomes the painstaking work of undergoing detailed governmental scrutiny, but those who grasp the intricacies of the process, complete the necessary groundwork and stay on top of events stand a far better chance of emerging unscathed.

*Healthcare Executive* spoke with a number of experts about strategies for coping with the arduous RAC audits that are soon coming every healthcare provider’s way.

**Be Seamless, Be Aggressive**

“Prepare properly, understand the process, and when you start getting denials, appeal everything you can,” advises Stephen W. Forney, FACHE, vice president of margin development for Ardent Health Services, Nashville, Tenn.

**What Is RAC?** The Recovery Audit Contract (RAC) program was authorized by the Medicare Modernization Act as a demonstration project and made permanent by the Tax Relief and Healthcare Act of 2006. Permanent and nationwide implementation is required by 2010. RACs are paid on a contingency fee basis to identify and correct improper Medicare payments. Providers have the right to appeal a RAC’s findings. For more information, visit [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC).
Unlike the comparatively benevolent connection between providers and fiscal intermediaries, the relationship between providers and RAC auditors is, for clear reasons, a bit more adversarial, Forney notes. This is not to say that providers and auditors can’t get along. But the organizations hired by CMS for RAC earn a percentage of what they recoup, which provides them with a powerful incentive to root out every possible overpayment. Hospitals need to take an equally aggressive stance in responding quickly, documenting their case and defending their position.

“"If a RAC finds a substantial pattern of errors that you have not corrected, under federal rules, those errors could be considered fraud."”
—Bill Phillips, FACMC, Revenue Strategies Inc.

Appoint a Chief RAC Officer

Providers will not be able to respond quickly or appeal effectively without first establishing an airtight operations management process for all things RAC. Most critically, that process requires a single individual designated to function as the core of operations as chief RAC officer—the conduit for every RAC request, response, denial and appeal. It also means communicating internally with crystal clarity who that person is to every area touched by RAC.

“"You need to have a person vested in this responsibility—someone to drive all of these pieces and keep track of (the process),"” Forney says. Although it doesn’t have to be someone from finance, “it should be someone far enough up in the organization to have cross-functional leadership who can interact with all of the constituencies and understand how the processes relate.” In addition to finance, those constituencies include health information management, legal, compliance, medical records, nursing and the medical staff.

According to Bill Phillips, FACMC, vice president and chief revenue officer of Revenue Strategies Inc., Fort Lauderdale, Fla., and adjunct professor of Healthcare Finance and Health Services Management at The George Washington University, Washington, D.C., many participants in the RAC demonstration project in California, Florida and New York were hit hard because they had not authorized someone to oversee the audits. These providers were overwhelmed by the volume of claims requested in the complex review—which can be as many as 200 every 45 days, or 10 percent of average Medicare claims in a month—and they incurred losses in many cases because they were not prepared to respond within the required 45-day time frame.

Phillips cautions providers that the auditors are under no legal obligation to send requests to a specific individual, even if a hospital identifies a key contact. As a result, designating a chief RAC officer and giving this person high visibility throughout the organization may be the single most important step a provider can take to meet audit deadlines and control losses, he says. “It should be a senior person because it needs to be understood that when a request comes in, everything else gets dropped in order to respond to it, or else you’ll be one of the hospitals that didn’t respond in time.”

Bret S. Bissey, FACHE, director of regulatory compliance for IMA Consulting, Chadds Ford, Pa., believes RAC responsibilities can be scaled to an organization’s budgetary constraints and size, but “at a minimum, you need somebody identified with the function of RAC coordinator and with the accountability to proactively structure and monitor (the audit) to make sure records are going back on time. It’s an administrative layer that’s different from anything else. I never recommend that a provider have a full-time RAC coordinator, but there ought to at least be somebody leading the charge to assess if you need one in the near term, because this process is so overwhelming.”

Bissey also stresses the importance of a knowledgeable, well-informed board of directors. “The bottom line is that managers and board members need to make sure the hospital has RAC high on (its) list of priorities and understands the financial risks of not complying with Medicare regulations,” he says.
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Ramp Up Your Processes

Forney and Phillips urge providers to become well acquainted with the clinical areas covered in the demonstration project and the clinical areas that will be reviewed in the national program, to conduct an internal audit to identify their level of risk and troubleshoot problems before the program begins, and to establish several key systems.

Specifically, they recommend the following actions:

**Identify all cases at risk.** Know the target areas for your state. This information is available at the CMS Web site and at the Web sites of the four audit firms hired by CMS. “We know from the demonstration and from the RAC firms’ sites what the targets are going to be,” Forney says. “These vary slightly from RAC to RAC, but only slightly.”

Based on claims, assess your risk relative to each area. Are you documenting medical necessity, which is expected to be a major thrust of the audits? Do you have processes in place to ensure you are not providing services that did not have a physician’s order or did not meet clinical requirements?

Sample a cross section of your coding over time and check all of the gradations that will be covered. If errors are identified, are they isolated errors or is there a pattern? If there is a pattern, what is the root cause? Was everyone in the coding department educated incorrectly on an item, or are the errors due to a single coder who misunderstood?

Review specific claim, coding and medical necessity items internally for risk with a work group made up of health information management, medical records, coding and compliance staff.

Methodist Hospitals, headquartered in Gary, Ind., used an outside firm to perform a data scrub to identify areas of potential vulnerability. The firm discovered that handwritten queries for physicians from other caregivers—potentially vital pieces of documentation—were being deleted from permanent medical records. As a result of the outside audit, “we now keep queries as part of the record to enhance our documentation,” says Loren Chandler, FACHE, Methodist’s vice president and chief financial officer.

Chandler advises providers to “review your information as soon as you can and try to replicate the RAC process as closely as possible to make sure any problems you have aren’t being compounded. The sooner you address your areas of weakness, the stronger your position,” he says.

For hospitals considering hiring an outside firm to review their data, Chandler also suggests using one that has a tool that approximates RAC capabilities. “If they don’t have a complicated tool, they won’t be able to scrub your data and come up with comparable results,” he says.

The firm Methodist hired had a nurse on its staff who had been an auditor in the RAC demonstration project, which provided the depth of perspective needed for a meaningful review. “If you can find a firm that has any type of direct link to RAC experience, you’re going to get better scrutiny and feedback,” Chandler says.

If RAC auditors request a record, they are probably 90 percent sure it has potential for denial, says Phillips. “They’ve had two years of experience already; they know what to look for. There’s absolutely no doubt that RAC knows the claims to target.” It behooves organizations to review the information published on RAC auditors’ Web sites.
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According to Bissey, documentation of medical necessity for short-stay admissions represents the single most critical audit risk area for hospitals. About 40 percent of recoveries in the RAC demonstration were in that domain. As the rules currently stand, if RAC denies an admission, it will request recoupment for the entire stay. If medical necessity is not properly documented for a one-day stay for a cardiac pacemaker placement, for example, RAC will ask for the entire payment.

“The sooner people get their arms around this and do an analysis of the gap between the regulations and what they are doing, the better off they will be,” Bissey says.

In the vast majority of cases, inpatient admissions are justified, but medical necessity is not reflected in the documentation “because in many cases, doctors don’t understand the financial impact of documenting it,” Bissey says. He also notes, however, that some hospitals are hurting themselves financially by going in the other direction and being overreactive to concerns about medical necessity. They have started putting patients under observation when, in fact, they could be admitted. Again, the documentation is missing, he says.

“Somewhere between these two scenarios is the sweet spot,” Bissey says. Getting there means partnering with the medical staff to make sure physicians understand the importance of proper documentation. He explains, “If the clinical documentation is accurate, the hospital reaps benefits downstream beyond the opportunity to avoid a RAC request, including appropriate revenue.”

Bissey suggests that providers offer sessions to the medical staff specifically designed to educate them about the impact of documentation on the outcome of the audits. He also advises using management tools to identify physicians who are contributing the most to documentation issues and to help them better understand the financial impact of their actions. “For hospitals, it’s a really critical function, because if you don’t start correcting it, you are helping RAC identify more bad claims, and you’re going to have a lot of risk,” he says.

Prioritize recoupment impact by target area. Some target areas will involve large dollar amounts; others will be smaller. These target areas will become apparent quickly. The auditors can request records going back only to Oct. 1, 2007, so “most of the records will be quickly identifiable and available” because they have been digitally scanned and stored, says Phillips. The demonstration project covered a five-year span, which made finding records and responding quickly considerably more daunting.

Establish a RAC repository for requests, denial letters, appeals, policies and procedures, and other documentation to track every interaction between your organization and the auditors. The repository should allow you to look at trends over time, including the reasons for recoupment, how many cases have been appealed, how many cases are scheduled for appeal and why you are appealing.

“This is going to be your database record that creates your RAC audit trail,” says Forney. “Not only can you look

Ask the Expert

Have a question on this topic? Continue the discussion on the ACHE Message Board. Stephen W. Forney, FACHE, will take your questions on ACHE’s Message Board from Jan. 1 to Jan. 31. Responses will be posted each Monday. Visit ache.org/Messageboard to post your questions and view his responses. When you post your question, please title the subject “HEMag/Jan/Feb/RAC [question here].”
internally to understand what you have done, but if anyone externally ever questions you on it or wants to go back and look at what you are doing, the data will be there.”

**Test the work flow.** Run a test with a hypothetical request to make sure you can respond within the required 45-day time frame. Make up some requests to test the process and see how your organization will respond to a complex review.

Write a letter requesting 10 medical records and mail it to your chief RAC officer to see if those records are generated in a timely fashion. Pinpoint where the process falters. Keep in mind that nothing in current law requires RAC auditors to send a request to the person you designate as a contact. “Even if requests are not being sent to the wrong person intentionally, there are plenty of opportunities for it to be done inadvertently,” says Forney.

“People change jobs, and it doesn’t take long before the information (RAC auditors) may have had in the beginning of the process is outdated. How many times have you tried to change the information in a system and seen it keep getting backed up?”

**Appeal aggressively.** The fact that “the percentage of reversals for appeals done in a timely fashion is extraordinarily high” provides perhaps the strongest argument for providers to pursue every possible appeal, notes Forney. Ninety-five percent of first- and second-level appeals in the demonstration project were successful, which means that the aggressive appeal of denials is in every provider’s best interest. “On the one hand, it’s a lot of work for hospitals, but on the other hand, it’s encouraging” that so many denials were overturned, he says.

Phillips notes that “even if a cost/benefit analysis reveals it will cost more than you would win back to appeal, there is still a benefit to being aggressive because the RACs—for-profit entities with finite resources—are going to focus on easier targets.” He adds, “RACs will be more circumspect with organizations that are aggressive than with those that write a check.”

Phillips points to other reasons to appeal: “If a RAC finds a substantial pattern of errors that you have not corrected, under federal rules those errors could be considered fraud.” Significant losses also can occur “if you’ve received a denial, but you are not wrong and you don’t appeal it,” he says. “You could wind up on the hook for other claims that were handled in the same way.”

Bissey recommends keeping the appeals process internal rather than outsourcing it. “The opportunity is to try to learn from it inside so you become skilled and enhance the education of your people and empower them to do this well,” he says. “It’s tough, but if you invest in it now, it should pay dividends in the long run because you are going to be dealing with this on a routine basis going forward.”

Adds Phillips, “The train has already left the station, and it’s simply a matter of time before every hospital in the United States is going to be subject to some sort of recoupment. What is unknown is how large the recoupment will be compared to the losses in the demonstration. It’s my fervent hope that the appeals process in the national program will be so successful that CMS will reconsider whether this program is effective enough to continue.”

**Related ACHE Resources**

Stephen W. Forney, FACHE, and Bill Phillips, FACMC, will present “10 Critical Actions CEOs Must Know to Minimize RAC Recoupment” at the 2010 Congress on Healthcare Leadership, March 23. For more information on this session, visit ache.org/Congress or contact ACHE’s Customer Service Center at (312) 424-9400.

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MDROs: Helping CEOs Uncover the True Costs and Take Action

New Toolkit Provides Strategies for Senior Leaders.

“The MDRO toolkit provides a structured guideline to analyze the impact of multidrug-resistant organisms on hospitals.”

—David B. Acker, FACHE
CEO
Canton-Potsdam (N.Y.) Hospital

The spread of multidrug-resistant organisms (MDROs) carries vast patient safety, clinical and economic consequences, which many CEOs don’t fully recognize.

Hospitals may have programs in place to combat MDROs, but most executives don’t know the costs associated with these superbugs in terms of the extra resources expended to treat patients or the number of deaths that result from MDROs.

Joint Commission Resources (JCR), a nonprofit affiliate of the Joint Commission, is providing guidance to healthcare organizations with a free toolkit, “What Every Health Care Executive Should Know: The Cost of Antibiotic Resistance.”

The toolkit, produced by JCR and funded in part by Ortho-McNeil, a division of Ortho-McNeil-Janssen Pharmaceuticals Inc., can be used by organizations that have an MDRO program and those that want to create one.

“We developed the toolkit for senior executives so they would better understand and embrace the whole issue of bacterial resistant diseases—that it is an important healthcare problem and needs C-suite support,” says Barbara Soule, RN, practice leader, Infection Prevention and Control, JCR, and co-editor of the toolkit.

Says Larry Westfall, PharmD, director, Quality Management, Ortho-McNeil: “Quality and safety initiatives don’t succeed unless there is buy-in from the C-suite. We approached development of the toolkit from the C-suite perspective in terms of what senior executives could do to make their hospitals safer.”

The toolkit, for example, provides direction to closely monitor how antibiotics are used and how the hospital can support physicians who prescribe them, says Soule.

The toolkit is composed of seven chapters such as “Antibiotic Resistance: Patients and Hospitals in Peril,” “The Clinical Consequences of Antibiotic Resistance” and “The Financial Impact of Antibiotic Resistance.”

“The toolkit strongly encourages hospitals to implement and support an antimicrobial stewardship program, which involves having a clinical pharmacist—preferably an infectious disease pharmacist—work closely with physicians, physician assistants and advance practice nurses to keep them on track,” says Soule.

CEOs are flooded with material to help them run their hospitals more effectively, and it is difficult to sort through it all.
But the MDRO toolkit is different because it helps CEOs clarify the issues and points CEOs directly to where their hospitals are with this problem, says Stephen Weber, MD, medical director of Infection Control and Clinical Quality at the University of Chicago Hospital.

Weber helped write and edit the toolkit and says it was designed with CEOs in mind, but all senior leaders can use it.

“Each section in the toolkit has top line points and questions a CEO should read,” says Weber. “CEOs need to get a general sense of the questions and then start to operationalize the toolkit, which works successfully when it comes from the CEO’s desk. I want the CEO’s curiosity to be piqued before he delegates toolkit responsibilities to other managers. We divided the book up this way so that chapters can be delegated to relevant areas.

“The situation of MDROs is getting worse all over, and now is the time to get your arms around the problem. If hospitals can get on the pathway, it will pay enormous dividends,” he says.

**A CEO’s Perspective**

Like most senior leaders, David B. Acker, FACHE, CEO of Canton-Potsdam (N.Y.) Hospital, has a lot to think about, and until two years ago the impact of MDROs on his organization wasn’t foremost on his mind. It was then that a patient’s husband called Acker to inquire why the hospital billed his wife for small charges associated with treatment of a bacterial disease that she acquired while in the hospital.

The disease had severely impacted the couple’s daily life. The wife was no longer able to engage in normal activities because her immune system had been compromised, and the relationship between husband and wife was now that of caregiver and care recipient.

Prior to the husband calling, Acker had no knowledge of the patient’s hospital experience. He arranged for the husband to tell his story to the entire hospital, as Acker believes transparency is important when dealing with MDROs. Acker then set out to better understand the frequency, pattern and trends of MDROs at the hospital. These efforts led him to collaborate with JCR to develop the toolkit, which Canton-Potsdam Hospital also uses.

“Use of the step-by-step processes contained in the toolkit helps an organization assess the current state of its readiness to combat MDROs and to then improve its capabilities to manage them going forward,” says Acker. “As our hospital has implemented many of the recommendations contained in the toolkit, we have seen areas of marked improvement. One of our primary areas of focus was on containing the spread of hospital-acquired Clostridium difficile (C-Diff). We saw a sharp increase from 2007 to 2008. That trend continued during the first quarter of 2009. We have not experienced a single case of hospital-acquired C-Diff in five months. The direct correlation between our housewide efforts to implement those recommendations and the drop in hospital-acquired C-Diff cases is unmistakable.

“Making your hospital the safest place should be every CEO’s highest priority. There are dangers with MDROs that all CEOs should be aware of,” he says.

**To get the free toolkit, please go to www.jcrinc.com/MDRO-Toolkit. For more information, please contact Larry Westfall, PharmD, director, Quality Management, Ortho-McNeil, at (610) 518-7298 or Lwestfa1@its.jnj.com or Christopher Herbine, director, Quality Programming, Ortho-McNeil, at (215) 766-8818 or cherbin1@its.jnj.com.**

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