

# Lessons From the Recovery Audit Contractor Demonstration Project

One hospital's experience in developing best practices



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There is certainly no better or harder way to learn than from experience. During the course of the Recovery Audit Contractor (RAC) demonstration, over a two-year period of time, the case-study hospital (CS Hospital) experienced considerable RAC activity as seen in the table in Figure 1.

**FIGURE 1: TWO-YEAR RAC DEMONSTRATION EXPERIENCE**

<b>RAC ADVERSE DETERMINATIONS</b>	<b>0.5% OF TOTAL REVENUE</b>
<b>INPATIENT MEDICAL/ SURGICAL CRITERIA-BASED</b>	<b>64% OF ADVERSE RAC AUDIT DETERMINATIONS (900 CASES)</b>
<b>NOT APPEALED</b>	<b>56% OF INPATIENT MEDICAL/SURGICAL CRITERIA BASED CASES</b>
<b>APPEALED</b>	<b>36% OF DETERMINATIONS</b>
<b>OVERTURNED TO DATE</b>	<b>15% OF APPEALS*</b>

\* A significant number remain in the appeals process.

The policies and procedures of this one hospital will continue to emerge and evolve, of course, but here's a look at its experiences in developing best practices to mitigate the financial risk associated with RAC audits.

## BUILD A BEST-PRACTICE ADMINISTRATIVE INFRASTRUCTURE

At the onset of the RAC demonstration project, there were many uncertainties concerning the expectations and demands of the RAC program. As such, the CS Hospital responded to its first RAC audit requests with a reactive, fragmented, inefficient, and costly approach. However, building on lessons learned and its earlier experiences, the CS Hospital now functions with an efficient and cost-effective administrative structure. Following are a few recommendations based on the lessons learned.

### Recovery Mitigation Committee

Each hospital or hospitial system should maintain a core team that meets on a regular basis. For the CS Hospital, this group includes representatives from a number of internal groups: finance, revenue cycle, medical leadership, case management, reimbursement, coding/diagnosis-related groups (DRGs), compliance, medical records/records requests, billing, and patient financial services.

A committee charter or mission should be established that includes the following basic provisions:

- Assume responsibility for data integrity related to all recovery reviews and audits, including commercial, Medicare, and Medicaid.
- Develop and maintain a process for sharing regulatory information.
- Ensure pertinent staff stay current on coding guidelines.
- Establish and enforce accountability processes.
- Hold regular meetings to share recovery-review and audit findings along with regulatory updates.

### Getting it right the first time

There are several administrative tasks that hospitals can begin right away, ideally before the first RAC audit. An assessment can be done that will help create a customized list of required tasks based on each hospital's environment.

As an example, the RAC will pay for producing the records related to an acute-care inpatient prospective payment system (PPS) hospital (or DRG), and/or long-term-care claim in accordance with the current formula under Medicare or any applicable payment formula created by state law. Hospitals should validate that their medical-record copying fee negotiated with any medical-record copying service vendor is consistent with the RAC rates. It is important to read the contract's fine print to ensure that the potential volume of RAC-requested medical records (10% of average monthly Medicare claims with a maximum of 200 records requested per 45 days) will not exceed the rate of reimbursement.

The RAC is limited to a three-year *look-back period*, with a maximum look-back date of October 7, 2007. Procedures should be established to ensure retention of historical coding sources such as DRGs, diagnosis and procedure codes, and criteria references in the event of an appeal.

Other preparations include, but are not limited to, establishing procedures to handle patient and family inquiries when they have questions about the CMS appeals letters, taking appropriate steps to avoid inappropriate patient billing with outstanding recovery-based balances, and ensuring the advance beneficiary notice (ABN) procedure is appropriately implemented to identify when the hospital is without fault with respect to overpayment.

**Map out the RAC response workflow**

It is imperative to establish and document a process workflow and accountabilities. Here are just a few of the questions that need to be answered:

- Who will be the single point of contact?
- Which area will receive and track all correspondence and each case's status?
- How will each department be notified of audit cases that need to be addressed?
- Who will be accountable for addressing DRG coding cases?
- Who will be accountable for addressing medical-necessity cases? In the rehabilitation unit? In the psychiatric unit?
- What financial thresholds will be implemented for determining appropriate cases to appeal?
- Which area will be responsible for addressing discharge disposition cases?

**BUILD A BEST-PRACTICE APPROACH TO MITIGATE THE RISK**

In the remainder of this paper, we discuss in detail the latter three parts of our four-pronged approach for a hospital to mitigate its potential financial risk associated with RAC audits, seen in Figure 2.

The first step for hospitals to mitigate the potential financial risk associated with RAC audits is to conduct an initial data analysis and operations assessment. This assessment will help lay out the strategy and tactical approach to minimize administrative costs and RAC recoveries.

**FIGURE 2**

Assess	Focus	Prevent	Manage
<p><b>Evaluate:</b>                      Admit appropriateness                      Chart documentation                      Accurate coding                      Audit response</p>	<p><b>Identify:</b>                      Vulnerabilities                      Inefficiencies                      Documentation improvement                      Ongoing effectiveness</p>	<p><b>Prevent:</b>                      Care deficiencies                      Poor documentation</p>	<p><b>Implement:</b>                      Appropriate appeals                      Cost-effective appeals</p>

**FOCUS**

There is a wealth of information available for hospitals to identify where they should focus their efforts related to the RAC audits. It is helpful to review the improper payments that were found by RACs during the demonstration project, on the Centers for Medicare and Medicaid Services Web site at <http://www.cms.hhs.gov/rac>. Permanent RAC findings will be listed on each RAC's Web site.

In addition, it is useful to review the improper payments that have been found in audits conducted by the Office of Inspector General and the Comprehensive Error Rate Testing Program (CERT). Also, CMS's Improper Medicare Fee for Service (FFS) Payments Report provides a wealth of information. For example, the most frequent medically unnecessary errors listed in the May 2008 report include:

**FIGURE 3**

DRG	DESCRIPTION	PAID CLAIM ERROR RATE
143	CHEST PAIN	17.90%
243	MEDICAL BACK	17.00%
182	ESOPH, GASTROENT & MISC DIG DISORDER AGE >17 W CC	10.30%
296	NUTR & MISC METAB DISOR AGE >17 W CC	10.30%
294	DIABETES AGE >35	9.40%

Hospitals should already be looking at their Program for Evaluating Payment Patterns Electronic Report (PEPPER) reports and considering audits in the target areas that are at or above the 75th percentile, or at or under the 10th percentile.

Finally, you can anticipate that the RACs will focus on new regulations. In 2009, these will likely include Medicare Severity DRG (MS-DRG) complication/comorbidity assignment, Present on Admission, and expanded transfer DRGs.

## PREVENT ADVERSE AUDIT DETERMINATIONS

Even best-practice hospitals will have RAC audits. But the best approach to mitigate the risk is to avoid inappropriate billing, particularly in the focus areas identified.

### Educate, educate, educate

After an initial assessment of risk areas, develop a formal education and reinforcement program. The education program should address all relevant areas and *dive deep* into potential problem areas. For example, a program should be developed to educate staff and physicians on basic documentation requirements and areas that will likely be targeted by the RACs. Case management staff can be used to prompt physician documentation. Nurses should be encouraged to document both the decubitus ulcer stage and location. Nurses and dietary should be encouraged to document the body mass index (BMI) in obese patients.

### Admission procedures

A process should be developed to encourage appropriate designation of observation versus inpatient admission. The CS Hospital encouraged attending physicians to use their “admit to integrated case management (ICM)” order. A case manager reviews all prospective admissions within 12 to 18 hours of admission and notifies the attending physician of the appropriate status.

To reinforce the importance of the process, the CS Hospital established an internal quality index (QI) measure related to condition code 44 on outpatient claims. This is used when a physician orders inpatient services but, before the claim is submitted, an internal hospital review determines that the services do not meet its inpatient criteria and changes the patient to outpatient status.

### Ensure appropriate documentation

There are several important steps in ensuring appropriate chart documentation. The first is to proactively promote appropriate documentation. The CS Hospital has case managers apply evidenced-based guidelines to all Medicare admissions. Continued-stay reviews are prioritized based on risk areas (diagnosis, physician) to optimize effectiveness of resources. The case managers prompt physicians for guideline-based documentation. They use a query or prompting process to have physicians clearly document the clinical status of the patient and factors influencing their care, including complications and comorbidities affecting the care of the patient or length of stay.

The CS Hospital maintains the query form as part of the documentation. This requires development of standards and specialized training in methods to seek factual clarification. It opted for this approach because it has a complete electronic record and wished to avoid use of e-sticky notes, which may inadvertently become a part of the permanent medical record.

Finally, to proactively address specific areas of vulnerability, the CS Hospital implemented a process to review charts meeting target criteria before billing to ensure appropriate documentation. Based on the findings, its Recovery Mitigation Committee reviews and reestablishes the criteria on an ongoing basis.

## Best use of the medical director

Physician involvement in the process is essential. Case managers should refer inpatient cases that don't meet medical-necessity criteria to the medical director. The medical director can review each case, document the findings, and attempt to intervene directly with the physician when indicated. In the case of the CS Hospital, the medical director prospectively ranks cases (e.g., 1, 2, 3) based on the strength of the case to meet the guidelines and on the anticipated ability to successfully appeal if subjected to an audit.

## MANAGE RAC AUDIT FINDINGS

### Prioritize

To minimize administrative resources, a triage process can be used to determine which cases to appeal. Only those cases where the appeal is possible or likely to succeed should be acted upon. And remember, each case stands on its own.

Medical-necessity cases can be evaluated by reviewing case management and medical director notes to determine the strength of the case before conducting a comprehensive chart review.

The prioritization process should include data on historical effectiveness of similar appeals. In addition to the strength of the argument, consideration should be given to establishing a minimum claim-dollar threshold based on the administrative cost to appeal (some estimate costs of \$2,000-\$3,000 per claim appealed).

### Standardize policies and procedures

A comprehensive set of policies and procedures related to audit response should be developed. The first should address responding to RAC record requests and include a process to ensure that the RAC receives the record well before the limit of 45 days from the date on the request. Although it may appear minor, it is helpful to sequentially number the medical-record pages (if the case is referred to an administrative law judge, the record will be referenced by page numbers) and save an electronic copy to use in the appeals process.

Record-keeping policies and procedures related to audits need to be addressed. Again, include simple policies such as “do not throw anything away,” because any record may be needed to substantiate efforts to respond to the audit. Include a procedure to mail all materials with a receipt signature required.

### Tracking the process

A database is required. Among other information, details of each record request and response should be logged. It is important to also include:

- The party responsible for corrective actions and the appeal
- The details of each stage of the appeals process and the results

It is also important to track the time involved in each step to permit a cost/benefit analysis, which should be used to help evaluate future appeals.

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### **Beware of unintentional downstream effect**

Our final word of advice is to take heed and do not become too conservative. There may be unintended and inappropriate revenue changes because of process changes made to address RAC findings. An inappropriately overaggressive program may increase observation stays and length of stay, and inpatient lengths of stays.

Financial risk can be mitigated by applying evidence-based guidelines, documenting the clinical status of the patient based on those guidelines, and applying sound clinical and coding principles. It's as simple, and as hard, as that.

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