THE TROUBLE WITH RACs

Providers struggle with the demands of the Medicare audit program and question the fairness of it all.

By Joseph Goedert

The Centers for Medicare and Medicaid Services in late 2010 launched its nationwide Medicare Recovery Audit Contractors program, employing outside RAC firms to conduct regular reviews of billings from hospitals—and to a lesser extent physician practices—to identify and recoup overpayments for services rendered to Medicare patients as well as identify and correct underpayments.

By January 2012, the program had recouped Medicare payments totaling $3.1 billion, according to CMS.

The program relies on regional contractors that receive a cut of the overpayments they identify and recoup. Those contractors can send requests every 45 days for additional documentation to support the claims submitted by providers being audited.

Since 2010, HealthDataInsights Inc., the regional RAC that has audited four-hospital CoxHealth in Springfield, Mo., has sent requests “on the money” every 45 days, says Carol Conley, director of audit and compliance.

The requests started with documentation demanded for 200 claims and soon doubled to 400 each 45 days. From 2010 until late 2012, CoxHealth’s RAC reviewed 5,236 claims. Sixteen percent of the claims—836—involved computer-automated reviews where the RAC denied the level of service billed.

The delivery system’s response has been to routinely downgrade the level of service on these claims and rebills, Conley says.

The vast majority of requests for documentation covered “complex” reviews of 4,350 claims, most of which were submitted years before. These reviews, Conley says, almost always center on the medical necessity of the inpatient stay of patients who were admitted to the hospital with the RAC contending they should have been treated in an observation or an outpatient setting.

New York-based HMS Holdings, the parent company of HealthDataInsights Inc., did not respond to a request for comments for this story.

“The denied Medicare Part A inpatient claim results in a significantly lower payment under Medicare Part B, providing reimbursement for diagnostic services only,” Conley explains. So, the reviews focus on the inpatient versus outpatient status of the patient, and that determination is made by the treating physician. RACs are reviewing these types of claims long after patients have received treatment and the outcome is known.

But at the time of service, a physician is often seeing a very sick patient and making a judgment call on whether observation or inpatient level of care is appropriate, Conley notes.
So, the RAC is taking the position that a patient wasn't sick enough to be admitted and the provider should have filed an outpatient claim, and is demanding documentation from the provider proving that the proper judgment call at the time was to admit the patient, she says.

The only recourse for hospitals in this situation is to appeal, Conley says. There are five appeal levels for complex reviews, although only the first three are generally used as most providers don't have the resources or see the wisdom in further appeals.

The first two levels are perfunctory functions where providers can appeal disputed RACs decisions to their Medicare contractor and then to a "qualified independent contractor" retained by CMS—and rarely succeed, Conley and other providers say.

CMS declined an interview request for this story and also declined to respond to concerns providers raised about the fairness of the program.

The agency in a statement said it offers providers assistance through a quarterly compliance newsletter and articles on its Medicare Learning Network, and noted it has implemented several edits to its payment system to correct problems that RACs have found.

Further, RACs make themselves accessible to providers by phone and e-mail, and meet regularly with national and state hospital and medical associations, according to the statement. "CMS is always looking for new opportunities to improve the program and welcomes suggestions by providers and associations."

These appeals have to done before a provider can advance to the third level and go before an administrative law judge, who is independent of Medicare contractors and RACs, and where a provider and the RAC present their arguments. This is where providers really fight the complex claims and where they often win.

**Costly undertaking**

RACs cost providers a lot of money that they already had in the door and now must repay. And it costs in time and resources spent.

At CoxHealth, the salaries alone of five employees dedicated to handling RAC requests—three nurses one certified coder and one billing specialist—total roughly $200,000 a year. And while RACs are supposed to also check for underpayments, providers say that is not a priority. Of the 5,236 claims CoxHealth's RAC reviewed in about two years, 19 resulted in underpayments that were corrected.

Providers have strong views on the fairness of RACs, but some also acknowledge Medicare's right to make sure it's paying appropriately. What they want, they say, is a more level playing field. So does the American Hospital Association, which recently filed a lawsuit against the RAC program (see story, page 62).

Leaders of RAC compliance operations in provider organizations vary by title; not all are directors of audit and compliance like Conley at CoxHealth.

Doctors, insurance managers and health information management directors are among others who oversee their organization's RAC work.

What's similar about the leaders is that they can't do the work without specialized information systems that enable them to track requests for documentation and submit them in a timely manner (forfeiting the opportunity to appeal if deadlines are missed), review records electronically, and use data analytics to score billings in dispute and identify those worth fighting.

Another similarity is the lament about the crushing burden of RAC audits, which don't include other Medicare audit programs, or audits by Medicaid programs and commercial insurers. Ministry Health Care in Weston, Wis., has had 4,500 claims audited under the Medicare RAC program alone, resulting in 600,000 pages of documentation. That's not a misprint—600,000.

And while auditors should be paying providers 12 cents per page submitted, “they have trouble counting,” alleges Larry Hegland, M.D., chief medical officer and leader of the RAC program at Ministry Health. “They seem to always undercount the pages we sent, then we send documentation and they usually pay.” But the average cost to Ministry Health is about 20 to 25 cents per page, he says.

In total, Ministry Health’s departmental budget for audit compliance is $800,000 a year—and that doesn't count the money it has to repay.

**Accidental boss**
CMO Hegland “fell into” overseeing 15-hospital Ministry Health’s RAC work and acknowledges “there are very few places that have a physician in this role.”

Others with more “appropriate” titles weren’t available, so Hegland attended a presentation on the RAC program.

He went back to his office and started sketching out a compliance plan for his particular hospital, then determined it made sense to develop a centralized plan for all hospitals to comply.

After sending his idea up the flagpole he was put in charge, and brought together revenue cycle, nursing, physician, case management and other experts to design a centralized program that handles all payer audit programs—commercial insurance audits are becoming more frequent and complex, Hegland says, adding that knows of hospitals on the East Coast where their commercial insurers are auditing more than Medicare.

To handle audits, Ministry Health employs a hybrid document management system using scanning technology from Canon and eCopy software from Nuance Communications to convert a scanned document to an editable PDF file, apply page numbers to the document to identify each page for legal reasons (called “Bates stamping”) and then upload to a multi-payer tracking database, called Compliance 360, from SAI Global Compliance.

One tracking feature is particularly helpful in identifying claims that have already been audited, but the same auditor or another auditor is asking for the same claims. Either way, a provider can decline duplicate requests if it has proof. The Canon system has a handy tool to highlight provisions in a document—such as vital signs and other health status indicators at the time a physician was deciding whether to observe or admit a patient—to help an administrative law judge better understand the provider’s justification for its charges.

Over time, Hegland has learned a few lessons about audits, the most important being that dedicated resources must be allocated to handle them well.

RACs and other audit programs are very dynamic and changing constantly, he notes. “If staff is doing the work without a lot of support and along with other duties, they don’t develop the expertise needed.”

Active education of case managers, coders and physicians doing the documentation is also important to ensure claims are as clear and proper as possible to make it easier for an audit to determine they are appropriate, and for providers to more easily appeal when they are contested.

Also, while the issue of medical necessity comprises the bulk of complex audits, RACs also conduct diagnosis-related group validation audits, to ensure medical conditions are properly classified, and that means coding training for nurses.

The biggest ongoing problem in audit compliance for Ministry Health is keeping the talent once the audit team has built expertise, Hegland counsels. An organization has to make staying on the team attractive as long as possible, while still offering opportunities for advancement. Having a positive culture and doing little things, like celebrating wins with a group lunch, are important. “We don’t demonize RACs,” he adds. “It’s hard to keep folks upbeat and having positive energy if you view audit programs as being evil.”

**Getting outside help**

To manage its RAC work, Shore Medical Center in Somers Point, N.J., uses software and outsourced services from MRO Corp., which specializes in handling release of information functions.

Shore Medical received letters requesting documentation for complex audit reviews eight times in 2011 and five times in 2012, along with a couple of automated reviews in 2012 that were not scheduled, says Richard Wicker, health information management services director.

The hospital got a reprieve from RAC audits in the fall after SuperStorm Sandy hit, but Wicker got a stack of letters for new audits in mid-January, which he takes to mean that the contractor did not reduce the number of audits it intends to conduct but just held the letters for a while.

Splitting the work with MRO, the hospital audit team opens requests for documentation, determines if they are valid, logs the requests in a Web-based release of information system from the vendor, pulls records to determine what information to release, and scans or uploads documents for release into the MRO system.

The hospital also uses audit tracking and analysis software from the vendor to coordinate audit processes for multiple auditors, organize provider tasks, process summaries, maintain requested documentation and auditor correspondence, and analyze trends and errors.
The vendor performs a series of quality assurance checks to ensure appeals letters are prioritized and deadlines met, verify the correct requester and address, check documents to ensure other files weren’t mixed in, determine transmission method (electronic file or paper) and ship the documents to the RAC, and track the shipments, among other duties.

Shore Medical also uses an outside firm to audit medical coding for appropriate DRGs. In addition to helping with especially challenging DRG denials, the firm will handle appeals of billings with RAC-deemed inappropriately coded DRGs on bills they have audited, and the firm will pay the difference if the appeal is lost.

During the past three years, the hospital has learned that there often are disparities between what a physician dictates and what shows up in clinical documentation, including codes.

Wicker believes the upcoming transition to ICD-10 code sets is a good opportunity to address this issue by educating coders and physicians on better documentation.

Double-check

Like Shore Medical, CoxHealth in Missouri also outsources some RAC work, but not a lot. With one exception, all the work is done in the audit and compliance department, says director Carol Conley.

The consultant firm Executive Health Resources reviews inpatient hospital stays to determine if the billing is appropriate at the time of service and before claim submission. The firm also appeals accounts they previously reviewed and deemed as appropriate for inpatient status. For other accounts not reviewed by Executive Health Reources, CoxHealth decides whether to appeal.

The overall denial rate is about 50 percent of the complex reviews done by the RAC, Conley says. CoxHealth appeals all denied accounts to the first level of appeal. Claims denied at this level are scored to determine the strength of the case for moving forward on appeal.

Third level’s a charm

Once CoxHealth gets before an administrative law judge in the third level of appeal, it so far has a 100 percent win rate on a limited number of appeals presented, she adds.

CoxHealth recently implemented audit management software from Craneware, which offers more tracking and analysis features and better workflow tools than the software the health system previously used, Conley says.

A critical new function is that CoxHealth can track and analyze decisions of administrative law judges to understand their processes.

When presenting appeals before administrative law judges, providers may get as little as five minutes to make their argument. The case is entirely focused on whether a regulation was followed. Consequently, providers have to make sure they have reference information readily available to the judge, such as the page number where proof of compliance is documented, Conley says.

She offers another appeals tip: Involve physicians, who provide excellent rationale for the medical necessity of an inpatient admission.

Depending on the judge, a provider may present its first case and the judge may ask if the argument on the others is the same. If so, the judge will hear the other side and then make a decision on the batch billings in dispute.

Providers Say They’re Looking For A Level Playing Field

Here’s how it breaks down for Larry Hegland, M.D., CMO and leader of the RAC program for 15-hospital Ministry Health Care in Weston, Wis.:

A physician assessing a patient in the emergency department to determine if the patient should be under observation or admitted to the hospital isn’t thinking of whether the resulting claim will be a Medicare Part B outpatient claim or a more expensive Medicare Part A inpatient claim.

The care is the same he or she would give any patient in a situation similar to the one now being treated. The physician is considering severity, the degree of resources needed and the complexity of possible complications, among other factors. Case managers also are looking at snapshots in time, such as current severity and necessary resources. They aren’t considering the risk of disease quickly progressing, or chances of rapid improvement.
Months or years later, an auditor at a Medicare Recovery Audit Contractor is looking at the claim of a patient that was admitted, knows the outcome of the treatment, and decides that patient should have remained on observation status rather than being admitted because the patient quickly stabilized and observation was all that was needed. And the auditor will ask the hospital to repay the difference in the observation and inpatient charges, plus 11 percent interest. Oh, and by the way, if the auditor finds a claim that was underpaid, it will send the hospital a check for the difference plus interest—at 2 percent. Is the process fair?

It isn’t, Hegland says. The RAC audit system is designed to push toward selection of observation status to start, he contends. And two initial levels of appeals of RAC decisions almost always uphold the decision, says Carol Conley, director of audit and compliance at CoxHealth in Springfield, Mo. It’s only when providers can appeal before an administrative law judge who doesn’t work for Medicare or the RAC that objectivity is brought to bear and that the judgments of physicians making decisions at the time they are treating patients are considered, they say.

“We want to do the right thing,” Conley asserts. “We want to follow the guidelines and what isn’t fair in the first place is that the guidelines aren’t clear.”

Hegland readily acknowledges that Medicare has the right and the fiduciary obligation to ensure it’s only paying for appropriate care. But even if a provider is trying to submit proper charges in good faith at all times, there are plenty of times when the charges aren’t accurate, he adds. The sheer complexity of Medicare rules for generating, coding and submitting claims makes the playing field unlevel from the start. “The coding rules are so byzantine that it is virtually impossible to submit a perfectly valid claim.”

Under the RAC program, auditors can ask for request for documentation on claims dating back to 2007. That means when the program started in 2010, RACs were asking for information up to three years old, and that is an unnecessary burden, says Richard Wicker, health information management services director at Shore Medical Center in Somers Point, N.J. “It’s like getting a ticket from a red light camera from three years ago.” Consequently, the hospital has lost some appeals on these older complex reviews, he adds. “You’re reading this chart from three years ago trying to figure out what you did.”

RAC program administration is now before the courts after the American Hospital Association filed suit in November 2012. The AHA charges that RACs judge the medical necessity of treatment months or years old. Further, hospitals win the large majority of appeals before administrative law judges, the AHA contends, yet CMS refuses to provide adequate reimbursement. Consequently, Medicare is flat-out not paying for a large chunk of appropriate care while RACs get a bounty, according to the lawsuit.

CMS declined to comment on the lawsuit.

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