Understanding and Managing RAC  

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Get it under control with the right resources

In just two years, a federal program to revisit paid Medicare claims and take back improperly billed disbursements has risen from minor financial annoyance to major factor in the budgets of providers, from the cost of fighting or complying with audit decisions to the impact of Medicare dollars repossessed from health care organizations.

A recovery audit contractor system of scrutiny that started sleepily in mid-2010 went from collecting $800 million in overpayments in fiscal 2011 to nearly $2.3 billion a year later. Belying those figures are high success rates for appeals of voluminous payment denials — but only after much grinding of gears by machinery set up to furnish loads of medical records on demand, meet exacting timelines for submitting required information and file a lengthy succession of appeals.

"The dollars at risk are becoming increasingly visible at the more executive level and potentially the board level," says Karen Bowden, senior vice president of consulting at Craneware InSight. "It's a huge, huge amount of work [to respond to RAC audits], and then the denials follow about 45 days later."

The RAC program is a government search-and-recovery mission bent on identifying suspect payout situations, scouring past claims for improper payment in those situations, requesting medical records to discern how claims were supported and demanding payments deemed undeserved. A hospital or other targeted provider can either accept the determination and return the money, or decide that circumstances not taken into account can be duly explained in an appeal to higher authority.

That thorny question — to appeal or not to appeal — is fraught with costly consequences either way, according to experts and provider —organizations steeped in the audit environment. Appeals succeed about 75 percent of the time, according to a RAC monitoring initiative by the American Hospital Association. But it takes a dedicated RAC function and plenty of know-how to stay on top of information requests and later write and manage multiple appeals.

"If at any point you miss a deadline, you're done; it doesn't matter if you're right or wrong, the government gets to recoup the money and keep it," says Larry Hegland, M.D., system medical director for recovery audit and appeal services for the 15-hospital Ministry Health Care system in central Wisconsin. That goes for submitting requested records in the audit stages as well as adhering to an appeals timeline. "There are rules in terms of how you submit documentation. If you don't follow all of the rules, they won't accept the record. And if that causes you to miss a deadline, well, that's just too bad."

But health systems that decide not to appeal — whether for lack of resources, an inclination not to fight, or a tacit admission of improper billing — face returning money they've already spent, likely in big chunks because of RAC incentives to target claims with bang for the buck, says Bowden.

Significant Revenue at Issue

After a quiet startup period that focused mainly on questioning providers' selection of diagnosis codes — choosing billing levels higher than justified — the program's four private contractors have shifted into high gear and homed in on medical necessity of services provided, most of which involve big revenue and the prospect of significant lost income for hospitals that cannot provide complex justification.

In questioning validity of a diagnosis-related group for a particular case, RACs are "getting the difference between the two payments," says Carol Conley, director of audit and compliance with five-hospital CoxHealth, Springfield, Mo. "Under medical necessity, you're giving up the entire payment. Instead of giving up $3,000 between the two DRGs, you're giving up the entire $20,000 for the DRG. That's way more attractive to CMS than dinking around with downgrading a DRG."

"They're clearly data mining to go after the biggest dollars, and they're targeting hospitals, targeting inpatient stays, because that's where the money is," Bowden says. "That's because RACs are paid a percentage of recovered payments. "Until they come to a point where there's diminishing returns, they're going to stay focused there."

RACs comb through Medicare claims databases for evidence of incorrect payment amounts, incorrectly coded services, duplicate services, and services not covered, including claims that are not reasonable and necessary. Some services are deemed so obviously improper that a demand for repayment can be sent to a provider via an automated procedure in which human eyes never review a medical record.
Most action, though, revolves around what's called a "complex review," where an auditor detects a service with a high probability — but not a certainty — of being wrongly billed. The RAC asks for specific medical records to determine whether a payment error occurred. Every 45 days, it can ask for additional records to supplement its initial investigation and launch a broader review of other instances like it.

RACs can't order an unlimited number of records, but the allowable load is still considerable. In 2012, some larger hospitals were required to submit up to 600 records per 45-day period, according to the AHA. Among 2,300 hospitals participating in a quarterly AHA survey of RAC activity, 623,000 requests for documentation were reported in the third quarter of 2012, an 80-percent jump compared with 347,000 reported in the fourth quarter of 2011.

"The RAC program is finally up and fully operational, which means that the impact to hospitals is greater than ever. That's true for all the RAC activities from the volume of medical records that they're requesting of hospitals to the numbers of audits and denials, and then that leads to a far greater appeals activity by hospitals," says Rochelle Archuleta, AHA senior associate director for policy. "So the attention and resources that hospitals are allocating to RAC activities are also greater than ever."

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**Admission Justification Pivotal**

One trigger for the increased activity is the spike in denials for medically unnecessary care, which in the third quarter of 2012 was the reason for 80 percent of all "complex" denials, the AHA survey reported. Medical-necessity denials related to brief stays of a day or two represented 65 percent of the total dollar value of complex denials, and six in 10 short-stay denials were not because care was judged unnecessary, but rather in the wrong setting — an inpatient stay instead of outpatient observation.

That single question, whether a patient should have been admitted as an inpatient under Part A of Medicare coverage or under less-intensive Part B coverage, is now the main RAC battleground, the biggest source of contested judgment and a principal focus of health systems' response efforts.

The clinical environment in which that question is answered is anything but contemplative. A physician typically needs tests and time to assess an elderly patient's acute complaint, which may take from a few to many hours depending on the presenting problem, the emergency department's load, the time of day or week, availability of testing and many other factors. Amid all that, a physician has to select a patient status — inpatient or observation — which Hegland says is "an artificial administrative construct that simply is there to tell the Medicare system, 'Are we billing through the Part A system or the Part B system?'"

Much of that responsibility, Bowden says, falls to a nurse case manager or other utilization reviewer who compares the patient's symptoms, physical condition, medical history and additional observations against a set of criteria — either commercially available or custom-built with consulting help — to draw an inpatient vs. observation conclusion that squares with Medicare rules. But only a physician can make the call to admit, and that may introduce judgment that can't be reduced to canned criteria, she says.

The information a doctor has to work with at the time may lead to the conclusion that a patient can't go home within 24 hours, even though it turned out that the situation brightened soon afterward. An auditor looking at that record retrospectively might flag it as a wrong call. For the physician in the moment, though, making that call would mean "having that crystal ball in advance to say, 'You'll recover nicely with some fluids,' but right now they're almost crashing," Bowden says.

For health care executives and governing boards, the odds of having a resulting claim denied or upheld on appeal are influenced greatly by the resources directed to that decision point and the clarity of the documentation that captures all the considerations that went into the decision. Aggressive RAC defense moves have included a push to bolster the admission order with detail that up front so that we bill it out accurately from the start.

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**Documenting Every Detail**

Too often it's not that simple. As with other operational issues, from quality metrics to ICD-10 readiness, "physicians aren't documenting for coding; they view the chart as a communication tool with other clinicians," Hegland says. "Excellent clinical documentation may not be very good billing documentation."

Not only must physicians address Medicare's ground rules for short stays, they also have to give RAC-response staff enough to go on in explaining extenuating circumstances, says Jennifer Jones, director of revenue recovery for Integris Health, which owns or manages 16 hospitals in Oklahoma. "It's important to code to the level of severity for the patient," she says. At Integris, aided by clinical documentation specialists, coders "try to make sure that the physician documents that up front so that we bill it out accurately from the start."

To understand how exacting that may need to be, consider the example of a patient in intensive care for a severe type of bacterial pneumonia called Klebsiella, which is "life-threatening, there's a good chance you're going to die," Hegland says. A sputum culture is a spot-on diagnostic for that nasty pneumonia, but if a doctor documents in the chart, "patient has pneumonia, positive sputum culture Klebsiella," a coding specialist may have no choice.
but to record it as simple community-acquired pneumonia, Hegland explains. Physicians looking at the chart may know it's Klebsiella pneumoniae, but Medicare requires "linkage language" — tying the pneumonia to the culture finding through the words "due to" or caused by.

Coders, Jones says, "are not allowed to make that leap." Only by querying the physician to make that link can the claim be billed appropriately. "Now, if we weren't able to make that linkage and we bill out community-acquired pneumonia, then the RAC is probably going to come in on that and say, 'Why was this patient there that long for simple pneumonia?' Any reading of the chart from a clinical standpoint would pick up the clear justification and the necessity for a higher level of care. It's one of many examples of "a good case to appeal" if denied on technical grounds, she says.

**Appeals Route Promising**

Many more provider organizations are warming to the appeal route as the scenario plays out again and again in the audit arena — and the odds of beating the RAC rap become more apparent. The AHA's quarterly survey results show a steady rise in the percentage of "complex" denials appealed, from 33 percent in fourth-quarter 2011 to 44 percent in third-quarter 2012.

"The impact of the RAC program is growing, hospitals are feeling it, those who have lower appeals rates are ramping up their appeals activity," Archuleta says. With 5,000 hospitals, approaches vary on appeals, she adds. "They have [a] very different scale of resources available, and expertise in-house to pursue appeals," which are expensive and very time-consuming. "The hospital has to make that decision as to whether it's worth engaging in an 18-month-plus exercise to get repayment."

At Integris, if an inpatient determination was questioned and denied by a RAC but the screening process supported inpatient status, and a concurrent review by a contracted physician adviser at the time of admission said it was appropriate, "then we go straight to appeal," says Jones. If not, a denial-management nurse reviews it and still may conclude it can be defended.

Integris has appealed 82 percent of denials and has a success rate of 94 percent for appeals decided so far, Jones reports. "I think that speaks to our strong up-front process, where we're reviewing those cases consistently and making sure that if it's inpatient, we've got criteria that can substantiate inpatient" (see Build the Right Team, page 11).

Appeals go first to a Medicare fiscal intermediary and, if the denial is upheld, the next step is a review by a "qualified independent contractor." The third stop on the appeal route is an administrative law judge. "We do have the best success at the ALJ level," says Jones, explaining that the full facts of the case often are entertained for the first time.

"It's the same information that we've presented at the Level 1 appeals, at the Level 2 appeals," she says. "The difference here is that you have a judge, who most of the time is nonclinical, and who is looking at it from a legal perspective, not just simply a clinical perspective," she says. A judicial reading of Medicare regulations taking into consideration a physician's judgment, rather than previous strict adherence to screening and coding output that leaves little room for that judgment, often wins the day.

**The Resources Necessary**

Governing boards not only need to know the cost of a dedicated staff expense for audit response, but also the success rate, Bowden says. As recently as a year ago, a webinar involving 200 participants on the subject of the RAC program posed an instant survey question on why the appeals rate at that time was so low; 79 percent said they didn't have the resources to commit to the arduous undertaking.

"Executive teams need to understand the financial risk and put the resources in place to defend," she says. That includes writing appeals, documenting improvement and such instruments as information systems to produce the supporting documentation.

"Initially everyone was concerned that we were getting denials, but once they recognized our success rate in overturning those denials, and our process we have in place, that alleviated some of that concern," Jones says. "You have to keep an open mind and understand that from our perspective, we don't want to be stuck with a terrible, inaccurate error rate [by not contesting denials]. So if we see a denial we feel is unfair, we're going to appeal it even if it may just be a $2,000 DRG."

Hegland allows that the appeals process is long and costly, but the final judgment is often the only judgment because of "definitional issues and limitations of the system. The admission process is driven by physicians who can exercise judgment; auditors and case managers use criteria that don't incorporate judgment," he says. "Most of the time the denials, those so-called improper payments, are actually proper," Hegland says. "The problem is that the system is not geared to allow you to properly bill until you can take the case to the ALJ to prove it."

**Sidebar - Build the Right Team**

Ministry Health Care has a centralized RAC function that handles all 15 hospitals as well as physician practices and other services subject to audit. Larry Hegland, M.D., a medical director for the central Wisconsin system, heads a team of nine, nearly all committed full time to evaluating and acting on a volume of cases that since early 2010 has required submission of 4,500 charts and 600,000 pages of
Funded at about $800,000 annually, the dedicated central office makes sense as a coordinated tactical response to all the incoming audit activity systemwide, Hegland says, and not merely for the economy of scale. RAC-response staffers have to concentrate on the sometimes tedious, sometimes intricate facets of a job where a lack of keen understanding or a momentary lapse loses the case, he says.

When the responsibility is one among many for an employee, that person doesn't have the exacting knowledge to stay on top of the rules. "You can't just give this to people and say, 'Send these charts in and then write appeals when we get denials,'" he says. "That's a recipe for disaster. These are complex issues."

CoxHealth devotes four full-time professionals — two registered nurses, a billing specialist and a certified coder — to its audit-response department for four hospitals in and around Springfield, Mo., says Carol Conley, director of audit and compliance.

Integris Health has a full-time manager for audits and appeals and three other half-time people in the department, including a nurse who helps review denials for possible appeal, says Jennifer Jones, director of revenue recovery for the Oklahoma system. The appeals part of the function is contracted out to a firm specializing in that service.

All three offices are organized to react not to just RAC audits, but the full array of government scrutiny over health care claims. They include Medicare administrative contractor audits, actions to preserve Medicare "program integrity" through claims analysis and investigations of potential fraud by the Office of Inspector General.

The audit-response team at Integris originally took shape in mid-2009 when MACs started doing prepayment reviews on the medical necessity of certain cardiology and other high-reimbursing services, Jones says. It produced a well-oiled tracking system for cases and a knowledge base expandable to other similar types of audits. "It reinforced how important it was to have the dedicated resources to monitor [cases] once the RAC audits started," she says.

Ministry Health's staff spends about 40 percent of its time on the RAC program, the rest on MAC audits, program-integrity inquiries, commercial audits and gearing up for the addition of RAC activity at the Medicaid level, Hegland says. The program started out fully on the RAC track, but gained expertise to be more efficient and able to take on more audit types, he says, adding that it required not only the right staffing resources, but enough of them.

Four nurses work to prepare an analysis of each case and draft appeal letters that run 12–15 pages, while four database coordinators upload records from a document management system to a tracking database to keep a running clock on deadlines for turning around documents needed for the next step in the timeline. One notable accomplishment given the complexity of rules is that Ministry has not lost one dollar because of failure to meet a deadline or follow the rules of record submission.

About 50 percent of Ministry's cases were being appealed until late last year when the rate was stepped up to about 80 percent, says Hegland. The success rate with appeals has been 85 percent, including 98 percent before an administrative law judge.

At CoxHealth, about 50 percent of the 5,300 accounts reviewed by the regional RAC have been denied, Conley says. Of those, about 45 percent have been overturned on appeal, though that number may be low because of a big backlog of still-undecided appeals, she adds.

The $200,000 annual cost for salaries remains justified not just for resisting repayment, but also for the
group’s role in educating hospital employees on the root cause of denials and keeping the leadership up-to-date on activity, Conley says. A monthly report to the board includes the number of accounts audited, the original payment amount in play, dollars pending somewhere along the appeals timeline, dollar value resolved and closed, and the net gain or loss. — J.M.

Sidebar - Online Exclusive
The RAC program adds a layer of scrutiny to the already complex inpatient vs. observation status decision, and it even can lead to an OIG investigation. Read this Web-only article at www.trusteemag.com.

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