

KEY TIPS TO A SUCCESSFUL RAC RESPONSE



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It's 4 p.m. on a Monday. You're starting to see the end of your workday and are beginning to wrap up projects and tie up loose ends, when across your desk comes a request from your recovery audit contractor (RAC) for 110 complex audits. Do you know what to do next?

The answer to this question will depend on whether your organization has prepared for the RAC audit process and whether it has a defined and tested approach to manage it. RAC audits require a full-scale, organizationwide preparation and response to minimize the financial impact, reduce future risk-exposures, and position your organization to improve the quality of its processes and delivery of health care. Creating such an approach also helps ensure you navigate the intricacies of a RAC audit and only give back money when necessary and appropriate.

An effective RAC response is predicated on two things:

- > A competent and interactive audit response team
- > A defined process for managing appeals for overpayment claims

“Without these two components, your RAC response will be haphazard at best,” says Gerilynn Sevenikar, vice president, patient financial services, at Sharp HealthCare, a 2,060-bed integrated health care system serving 3 million residents in and around San Diego. In 2005, Sharp HealthCare was part of the original RAC demonstration project.

“Without an audit response team, you have no

structured way of communicating about RAC requests, and without a process for managing appeals, you risk giving back money that in the long run you don't have to.”

CREATING AN EFFECTIVE AND INTERACTIVE RAC AUDIT RESPONSE TEAM

An audit response team should be a multidisciplinary group that helps to manage your organization's response to RAC requests, make decisions, and pursue appeals. “One of the biggest mistakes organizations make with regards to RAC is thinking that their health information management department can manage the process on its own,” says Sevenikar. “In fact, you need a team that includes representatives from every area that touches patients' Medicare claims. This composition ensures the best possible response to the RAC process.”

When designing its RAC audit response team, Sharp HealthCare took a systematic approach. “During the RAC demonstration, we looked at who was involved in the discussions about managing the RAC requests as well as when to appeal, what to appeal, and how to appeal,” says Sevenikar. “Those individuals who were critical to the discussions were asked to sit on our RAC audit response team.” For Sharp, the team includes the following:

- > CFO for each of the organization's seven hospitals
- > Manager of utilization management for each

of the organization's seven hospitals

- > Vice president for Patient Financial Services
- > RAC coordinators
- > Representatives from Health Information Management (HIM)
- > Vice president of Corporate Compliance

Currently, one of the organization's CFOs chairs the RAC audit team. "Having a CFO lead the team has helped underscore the importance of the subject matter," says Sevenikar. "Every member of the team is a guardian of our organization's revenue, and the presence and engagement of CFOs on the team helps emphasize this responsibility."

To be effective, an audit response team should meet regularly. For example, Sharp Health-Care's team meets monthly. "Initially, we thought that meeting monthly might be too frequent, because we weren't getting that many complex audit requests," says Sevenikar. "However, in recent months, the number of requests has increased significantly and the

monthly meeting is very helpful. During meetings we review any complex audit requests, delegate responsibility, and determine whether we are going to appeal."

Even during the initial slower period, Sharp's team used the time wisely. "We used the opportunity to do preemptive audits on our medical records to identify where potential problems might be," says Sevenikar. "We also refined our electronic monitoring tool to ensure that it was capturing necessary information and notifying us of key steps along the RAC process." By meeting monthly, the organization was prepared when it recently received a large number of complex audit requests. "Since we had spent time planning our response, we were able to immediately address the audit requests when they came in," says Sevenikar.

In addition to meeting regularly, effective audit response teams must clearly define responsibilities and accountabilities within the team. "The RAC process can be overwhelming, especially as the number of complex audit requests starts to grow," says Sevenikar. "Every member

RAC FAQs

What is the RAC program? Driven by the Centers for Medicare and Medicaid Services (CMS), the Recovery Audit Contractor (RAC) program is designed to identify and resolve Medicare overpayments and underpayments. Created initially by Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the RAC program became permanent and nationwide as of January 1, 2010.

What types of audits are involved in RAC? The RAC program involves two types of audits: automated and complex. In an automated review, a RAC contractor uses data mining techniques to identify Medicare claims with errors and make overpayment and underpayment determinations without evaluating the medical records associated with the claims. During a complex review, the RAC contractor makes overpayment and underpayment determinations after evaluating the medical records associated with the claims. Although it is important for hospital leaders to be familiar with both types of audits, the majority of the organization's prep work regarding the RAC program will likely center around complex audits.

How often can my organization receive RAC requests? Your organization can receive RAC complex audit requests every 45 days, and the quantity is based on a percentage of your organization's total Medicare volume. Many complex audits result in an overpayment claim, which requires an organization to give back the funds outlined. Your organization can appeal this claim if you feel it was made in error.

of the team should know what his or her role is in responding to a RAC request and also what the roles of the other team members are.” For example, individuals on the team should know where contractor correspondence is received in a facility and who is responsible for that correspondence. In addition, they should know exactly where to send organization communications and who at the RAC contractor will take delivery of them. “Without establishing responsibilities and accountability up front, some critical elements of a RAC response—meeting deadlines, providing requested data, talking with the RAC during the discussion period—may be missed,” says Sevenikar.

MANAGING THE APPEALS PROCESS

A fundamental activity involved in managing a RAC response is the appeals process. An organization engages in an appeal if it receives an overpayment claim—where the RAC indicates Medicare has overpaid the organization for services rendered—with which it disagrees. There are several benefits to appealing overpayment claims. “A successful appeal can stop recoupment and also create an outcome that supports future denials and appeals,” says Carol Endahl, product manager, hospital solutions, at Ingenix, a health information company

located in Eden Prairie, Minn., that provides technology, services, and consulting. “Such an appeal can not only ensure you keep your money, but also it can prevent you from losing more money in the long run.”

As previously mentioned, having a defined approach to managing the appeals process is key to ensuring you appeal appropriately, efficiently, and effectively. Such a process must begin with one central question:

> Is this an appropriate overpayment claim?

If the answer to this question is “yes,” then your organization should review the decision and determine how to prevent such a claim in the future. “Every overpayment claim should teach a lesson,” says Michael Taylor, M.D, vice president, clinical operations, at Executive Health Resources, a provider of medical necessity compliance solutions for more than 1,300 hospitals and health systems. “If an organization can learn from overpayment claims, then it can help prevent unnecessary overpayments in the future. This can reduce the financial impact of RAC audits and allow an organization to focus on appealing those decisions that warrant it.”

If the answer to the appropriate denial question is “no,” then your organization must decide

KEY PEOPLE TO INCLUDE ON THE RAC AUDIT RESPONSE TEAM

While every organization’s RAC audit response team will differ, the following are some key people to

consider including on your organization’s team.

- > Financial leadership, including the CFO, vice president of finance, and so on
- > Coding specialists

- > Case managers

- > Representatives from the legal compliance department

- > Physician advisers

- > Health information managers

- > RAC coordinators

whether it makes sense to appeal the claim. This requires an internal review in which your audit response team discusses and determines whether to move forward in the appeals process. Some considerations to keep in mind during this discussion include the following:

Was the Medicare claim coded properly? “If after reviewing a case, your RAC audit response team feels the Medicare claim was coded properly, then it may make sense for you to appeal,” says Endahl. “Make sure, however, that your appeal is supported by strong evidence: hospital admission and utilization guidelines, the American Hospital Association’s Coding Clinic citations, official guidelines for coding and reporting ICD-9-CM, and so forth. If you are going to spend the time and resources to appeal, then you should make sure that you have the justification in place to support that appeal.”

Was the care medically necessary? “Medical necessity is probably the most fundamental consideration in deciding whether to appeal a claim. However, many organizations don’t adequately consider this,” says Taylor. “A medical necessity review should involve a physician and focus on determining whether the organization has a case for medical necessity. Unfortunately, many organizations just send the claim back to the case manager who reviews the claim against certain screening criteria. If the claim doesn’t meet the criteria, then the case manager recommends remitting payment back to the RAC. However, such an approach doesn’t take into consideration those times where the claim doesn’t fulfill the exact wording of the criteria, but the care described in the claim still satisfies the Medicare coverage requirements for inpatient admission. If you don’t have physicians involved in answering the medical necessity



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question, then you may fail to resubmit a claim that could have gone through.”

As an example, let's say a patient with a history of chronic heart failure enters a hospital for treatment of an infection. While the typical treatment for a patient with some types of severe infection consists of high dose fluids and antibiotics, the presence of heart failure often necessitates slower administration of fluids over a longer period of time. In treating the patient, the physician prescribes the medically appropriate treatment, and the organization bills Medicare for reimbursement. Although the treatment provided to this patient may not exactly meet the first level screening criteria for reimbursement, the treatment is appropriate and medically necessary, and therefore may satisfy the Medicare requirements for admission. A physician could help identify this type of situation and determine whether appeal is warranted.

Is the claim financially worth appealing? There are definite costs associated with preparing, writing, and managing an appeal. “The American Hospital Association estimates that it costs about \$3,000 to appeal a RAC claim up to the third level, and that cost can increase as you go higher up the appeals process,” says Taylor. “Hospitals should be aware of the potentially high costs of appeal and should strive to ensure that their appeals are conducted in a cost-effective manner. An experienced physician adviser can help a hospital identify those cases that have merit for appeal, and to appeal those cases successfully.”

Are there other reasons besides finances that make appealing attractive? “Although financial considerations are an important factor in the decision to appeal meritorious cases, it should not be the only consideration,” says Taylor. “In some cases, a small claim that on the outside seems not worth the effort may be an essential claim to pursue. For example, there are certain situations where not appealing may affect future RAC contractor behavior. In other words, if you don't appeal the claim, it may imply a

tacit agreement with the RAC decision, and future Medicare claims with the same issue may be denied as well.”

“Certain overpayment claims are worth appealing just to support your organization's approach to care,” says Endahl. “If you do not appeal, you may inadvertently be giving the impression that you handled the situation described in the claim incorrectly when, in fact, you did not. In these situations, silence can convey a message about your organization and its processes that you do not want to convey.”

ONCE YOU DECIDE TO APPEAL...

Should your RAC audit response team take the previous considerations to heart and decide to appeal a claim, it is time to move forward. To maximize the return on the appeal, your organization should have a defined strategy that addresses how you are going to approach the process. This strategy should outline communication flow and make it clear who is responsible and accountable for different steps along the way. Following are several tips your organization should consider when structuring an approach to the appeals process.

Take advantage of the discussion period. Before the official appeals process begins, there is a period of time in which you can engage in dialogue with your RAC contractor. “If you can change a claim decision during this period, it may help you avoid some significant costs,” says Taylor. Some ways to engage in a dialogue may involve sending a letter providing clarification, or talking with the RAC's medical director regarding claims you feel particularly strongly about. “Although this approach may not work every time, using the discussion period to start the dialogue and provide clarification may help you avoid the costly appeals process in the long run,” says Taylor.

Build your case early on. To present a strong appeal, you should be sure to get all supporting information and evidence associated with the claim in to the appeals contractor by the second

level of appeal. After the second level, your organization may be barred from submitting any more information to justify your case. For example, if there is vital information from the physician's chart that will support an appeal, this information should be submitted by the second level or it will not be considered. "This is a mistake organizations often make," says Endahl. "By the time an appeal gets to the administrative law judge level (Level 3), your organization must be past the point of compiling all of the documentation necessary to make its case. You should have all supporting documentation in place or you may miss an opportunity."

Keep good records. "The RAC process is onerous enough without having to do rework," says Endahl. "Therefore, it's paramount to keep good records about each appeal. This can help create a foundation for future appeals and prevent the need to recreate the wheel each time you appeal a claim."

Don't give up. Although time-consuming and sometimes expensive, pursuing the appeal through all levels is valuable. "Many providers

have been successful at the administrative law judge level," says Taylor. "So even if you have not been successful at the first two levels, don't give up. There is still a significant chance your appeal will succeed at the higher levels of the appeals process."

AVOIDING PITFALLS WHILE ALONG THE WAY

As your organization navigates the RAC process, you may encounter several pitfalls that could delay or even derail your RAC response efforts. The following tips offer strategies for avoiding these pitfalls and ensuring a comprehensive and effective RAC response.

Know your organization. "An organization should not be surprised by RAC requests," says Sevenikar. "Those organizations who have done a preliminary audit of their medical records, as well as continuing audits as more RAC requests come in, should know where their risks are." One specific way to identify risks is to review the data your RAC contractor posts prior to

INTERVENTIONS TO REDUCE UNNECESSARY OVERPAYMENT CLAIMS

If your organization determines that some or many of its overpayment claims relate to a recurring pattern—such as improper coding—it is important to implement interventions that can address that pattern. Some possible interventions may include the following.

- > Assessing staff compliance with organization coding guidelines
- > Increasing training for coding staff
- > Establishing performance measures to improve coding accuracy and efficiency
- > Reviewing policies to ensure they reflect practice
- > Providing education for medical staff about improving documentation.

Whatever the intervention, you should track the effectiveness of the intervention and also see if it has an impact on future claims.

sending out RAC requests. “RAC contractors are required to post information about areas they will be looking at,” says Sevenikar. “This information includes a roster of DRGs. Your organization can review its activities in those areas and conduct targeted audits to see if you are at risk for RAC requests related to those areas. This information gives you a starting point for your risk assessment instead of just randomly auditing all medical records.”

Test your response process. If your organization fails to test its RAC response process, then it can get into a situation in which the process has flaws of which you are unaware. “Performing mock audits and testing your organization’s response can help identify weaknesses in your system and make sure you can handle RAC requests appropriately when they come through,” says Taylor.

Have a good tracking system. “The RAC process is full of deadlines. When you have many pending requests at different stages of response, it’s at best cumbersome, and at worst impossible, to keep track of these deadlines without a good

tracking system,” says Sevenikar. “Such a system should send reminders about deadlines, house template letters, and basically automate the response process.”

Embrace technology. “I would be hard pressed to find an area in an organization’s RAC response effort that would not be helped by technology,” says Taylor. “Technology can not only help you with deadline tracking, but also help identify patterns that can further pinpoint strengths, weaknesses, and areas of risk. Although the RAC response process needs a lot of human input, it can be assisted by technology in ways that make the process more accurate, more efficient, and more responsive.” With that said, technology cannot help make all decisions regarding the RAC request. For example, appeal decisions must remain with the audit response team. “Until computers can medically treat people, the ultimate decision on what to appeal must remain with humans,” says Taylor. “While computerized models can help clinicians better understand a patient’s risk of an adverse outcome, in the final analysis, only a

FIVE LEVELS OF MEDICARE RAC APPEALS

Following is a brief outline of the five levels of the appeals process. For more information on the different levels, go to

<http://questions.cms.hhs.gov/app/answers/list/p/8,7,496,497>.

> First Level - Redetermination

- Carried out by Medicare administrative contractor (MAC)
- Time Limit - 120 days from the date RAC payment was adjusted

> Second Level - Reconsideration

- Carried out by qualified independent contractor (QIC)

- Time Limit - 180 days from redetermination decision

> Third Level - Administrative Law Judge

- Administrative law judge (ALJ) hearing
- Time Limit - 60 days from reconsideration decision

> Fourth Level - Medicare Appeals Council

- Carried out by Medicare appeals council (MAC)
- Time Limit - 60 days from ALJ decision

> Fifth Level - Federal Court Review

- Carried out by the federal district court
- Time Limit - 60 days from MAC decision

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physician can make the admission decision.”

Assign one person to monitor all deadlines. Although an electronic tracking system can send reminders and prompt action, the organization also needs to have an individual who is specifically charged with ensuring that people respond to these reminders and meet deadlines. “There is no running late in this process,” says Sevenikar. “If you miss the deadline, you miss your opportunity. There are no extensions or reconsiderations. For that reason, it is critical that you identify someone who is going to keep on top of the process.”

Involve physicians as ad hoc audit response team members. Physicians play a significant role in the RAC audit response process—specifically with regards to appeals. “A physician can help your organization determine whether a decision should be appealed because of medical necessity,” says Sevenikar. “For this reason, it is important to get physicians involved on a RAC audit response team, at least on an ad hoc basis. Plus, as physicians are starting to get their own RAC letters, they have a heightened awareness and vested interest in helping the hospital navigate the RAC process. Organizations should capitalize on this enthusiasm and forge partnerships with the medical staff.”

Use data for performance improvement. The RAC process is full of data points that can help your organization improve its processes and streamline efficiency. “Regularly reviewing data about the number of overpayment claims, reasons for such claims, the number of appeals, success rate of appeals, and so on can help your organization identify where potential problems are,” says Taylor. “For example, if you discover that of the 30 requests you addressed last quarter, 25 of them deal with the same issue, then that may highlight a topic that deserves closer internal examination.”

Data can also help pinpoint areas on which to focus with regard to appeals. “If you determine that your success rate with certain types of appeals is pretty good while your success rate with other types of appeals is fairly low, then you may want to consider focusing your efforts on those appeals that are most likely to go your way,” says Endahl. Organizations can also use data to set benchmarks for further improvement. For example, an organization can set targets for reducing the number of RAC complex audit requests, increasing the rate of successful appeals, and so forth.

Don't assume the RAC is right. Organizations should not take every overpayment claim at face

DATA TO COLLECT FOR PERFORMANCE IMPROVEMENT

The RAC process is rife with data that your organization can use to improve the accuracy of its coding, billing, and documentation. Some fundamental data to review for performance improvement include the following.

- > Number of complex audits
- > Percent of audits that result in overpayment claims

- > Number of appeals
- > Percent of overpayment claims appealed
- > Success rate for appeals
- > Workload associated with appeals
- > Financial impact of the appeals

ARE YOU MINING YOUR DATA FOR COMPLIANCE RISK?

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value. “Do the work to defend your organization,” says Endahl. “Just because you receive an overpayment claim doesn’t mean you were actually overpaid. Ensure qualified people use concrete data to help review the claim, and if you have a case, then pursue the appeal to its highest level.”

PROTECTING THE ORGANIZATION'S FINANCIAL RESOURCES

Managing your RAC response does not need to be hard. In fact, with the right systems and processes in place, you can embed the response effort into daily practice. By proactively

identifying areas of risk, targeting interventions to reduce risk, using technology to manage the response process, and involving the input of multiple disciplines—including physicians—you can ensure that your organization responds appropriately and effectively to any audit requests, and only gives back money when necessary and warranted. Not every appeal will go smoothly and not every appeal will result in success, but if you have systems and processes in place to navigate the effort you can rest assured that you are effectively acting as a steward and protector of your organization's financial resources.



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