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Are You RAC-Ready?

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Between 2005 and 2008, the CMS' Recovery Audit Contractors (RAC) demonstration program has recouped \$693.6M for the Medicare Trust Fund from three states alone – California, Florida and New York.ⁱ Now permanent, the program has extended its reach with Washington, Idaho and Oregon slated for inclusion by January 2009 and all other states to follow by 2010. This is the first time that CMS has ever paid a contractor on a contingency-fee basis for claim review and over-payment collection work.

In spite of the apparent success of the RAC program and its likely longevity, H.R. Bill 4105, the Medicare Recovery Audit Contractor Program Moratorium Act attempts to affect a one-year moratorium, which seems unlikely. One reason RAC is not going away is that CMS costs, including the contingency fees, are down to approximately 20 cents for every dollar collected.ⁱⁱ This type of excellent return on investment is one that physician practices can only dream of reaching due to high costs of la-

bor, employee benefits, malpractice insurance and declining reimbursement from payors. Approximately \$2.8 billion, or 3.9%, of Medicare dollars paid did not comply with Medicare coverage, coding, billing or payment rules, according to the November 2007 Medicare Fee For Service Payments Report. Of the overpayments, inpatient hospitals and SNFs comprise 87%, outpatient hospitals 6%, physician practices 2%, Ambulatory, Lab, DME and other at 4%. This is the government's third largest payment error, behind Medicaid (\$12.9 billion) and Income Tax (\$11.4 billion) respectively.

While 2% may lead physicians to be less concerned about the RAC process, consider this: In the three states cited above, fiscal year 2007 cost the physician sector **\$12.2 million in paybacks**, with \$4.8 million of that **due to incorrectly coded claims**. The RAC DataWarehouse shows that the top physician services targeted by RAC were pharmaceutical injectables (CA), duplicate claims (CA) and vestibular function tests (FL). We must assume that CMS will target similar or the same services in its extended program, which means specialty practices should be on alert. For instance,

an Oncology practice, due to its high incidence of IV Infusions and medication use, could expect close scrutiny for appropriate units of medication and for following medical necessity guidelines. It's important to mention that the RAC auditors appear to be focusing on the same risk areas identified in the Office of Inspector General's work plan.

The audits are not usually done in person but rather through mail and remote dialogue. The RAC auditors use proprietary software and their in-depth knowledge of Medicare's rules and regulations to perform their work. Certified Coders handle coding reviews and Registered Nurses or therapists conduct Medical Necessity Reviews.

To prepare for RAC's arrival in Washington and Oregon, it is imperative that physician practices undertake internal and external billing audits **now** – from registration to reimbursement. A proactive approach reduces compliance risks of overpayment “take backs” that ultimately affect cash flow. Our top eight suggestions:

1. Conduct random chart sampling. Does physician documentation support the E&M level? Check consultations, drugs and procedures billed.

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2. Conduct an internal claim and revenue cycle review on high-risk claims.
3. Compare physician/provider coding utilization patterns with peers.
4. Audit duplicate claim processing and fix the problems.
5. Create a dynamic audit response team that includes a content expert in CMS billing rules for your specialty.
6. Implement corrective action: educate, educate, educate.
7. Re-audit and sustain process changes.
8. Self-disclose to CMS if you discover billing errors. Beat RAC to the issue.

questions. Develop a friendly and professional communication style with the assigned auditor, and have a single point-of-contact who owns and tracks all communications. Work with your legal counsel to make the decision to accept or appeal RAC's findings.

The RAC June 2008 report stated providers chose to appeal 14% of the RAC determinations. Of the 73,000 claims appealed, 33% resulted in decisions favorable to the provider. Given this relatively high success rate it is important to become familiar with the appeal process.

However, the five-step appeal process is onerous: Redetermina-

tary) says there are three ways to approach change: "You can fight it and fail, accept it and survive or lead it and prosper." If your organization's leaders decide to be proactive in auditing providers' charge, coding documentation and revenue cycle for accuracy, then they are of the third type. And that means the RAC initiative has served a good purpose: to promote getting your claims billed correctly the **first** time by knowing your data. Investing in prevention, rather than defense, is a much better use of your precious and limited resources.

Barbara Derry, Crystal Nolan and Melania Antonio of Derry, Nolan & Associates help Pacific Northwest medical practices, clinics and other health care organizations improve operational and financial health. The firm's proven health care and practice management methods focus on using resources effectively to drive profitability. Visit www.derrynolan.com or call 425.774.4893 to schedule your free, one-hour initial consultation.

ⁱ www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf, June 2008, page 2.

ⁱⁱ *Ibid.*, page 3.

ⁱⁱⁱ HCPRO, Inc., "Revenue Cycle Management Practice", William Malm, ND, RN, May 2008, pages 1-8.

Download the supporting diagram "Revenue Cycle Risk Management" at www.derrynolan.com/sitenews/media.php.

RAC REVIEW PROCESS

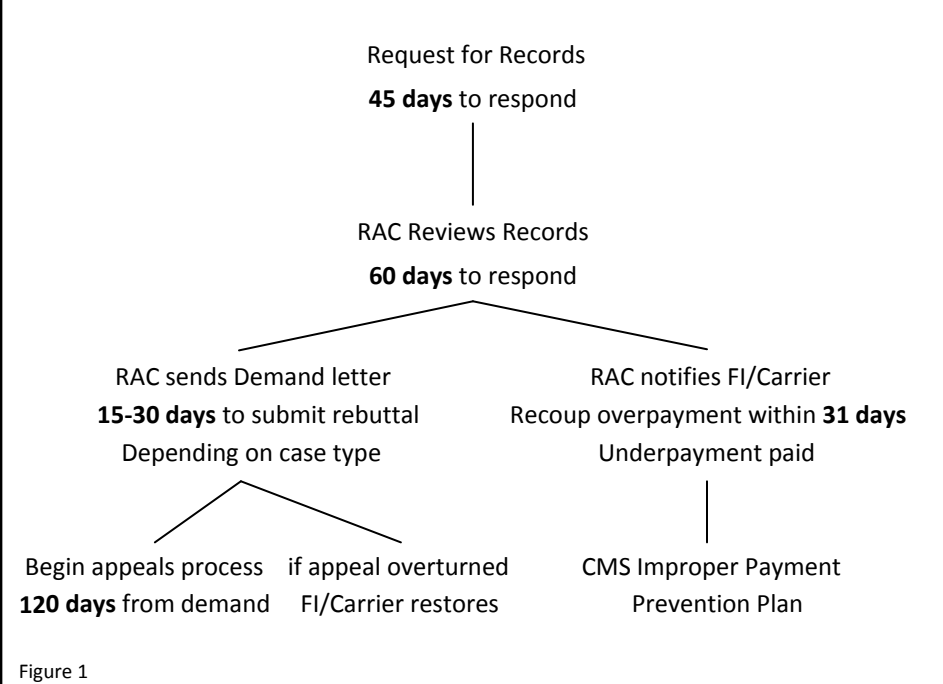


Figure 1

Pre-audits are only part of the preparation. Figure 1 illustrates the RAC review process. Staff needs to know how important it is to respond timely to RAC re-

tion, Reconsideration, Involvement of an Administrative Law Judge, Medicare Appeal Council, and Federal Court Review.ⁱⁱⁱ Michael Leavitt (DHHS Secre-