

*The three-year Recovery Audit Contractors (RAC) Demonstration Project ended in March 2008 and resulted in tremendous financial success for CMS, the Medicare Trust Fund and the Recovery Audit Contractors who were paid on a contingency basis for identification of improper payments. As of March 27, 2008, more than \$1.03 billion in improper Medicare payments were corrected. Approximately 96 percent – a whopping \$992.7 million – of the improper payments were overpayments collected from providers, while the remaining 4 percent – \$37.8 million – were underpayments repaid to providers. Most overpayments – about 85 percent – were collected from inpatient hospital providers when the providers submitted claims that did not comply with Medicare’s coding or medical necessity policies. Could your hospital be at risk of having its Medicare payments taken back by the RAC?*

## SURVIVING THE RAC: IT’S ALL IN THE DETAILS

**A QHR  
White Paper**



## Medicare's Statement on Medical Necessity:

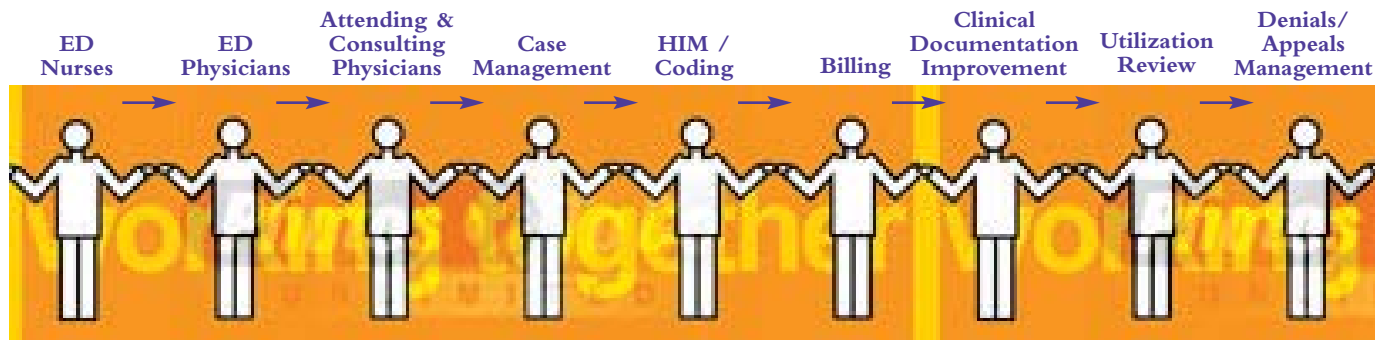
### *Title XVIII of the Social Security Act, Section 1862 (a)(1)(a) says:*

*"No payment can be made by Medicare for items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member." Unfortunately, this regulation doesn't explain how to establish medical necessity for services rendered in the hospital setting. RACs establish their own definition of medical necessity for inpatient versus outpatient observation, with little regard for clinical evidence-based medicine and designated best practice standards of care.*

## Assembling Your Team

The RAC doesn't use Interqual criteria as a guide to determine medical necessity. In fact, medical necessity, as far as the RAC is concerned, hinges on its reviewer's independent clinical judgment when reviewing claims for validity of inpatient versus outpatient observation status. Explicit and complete

medical record documentation is a prerequisite to effective defense and appeal of arbitrarily denied claims on the pretense of medical necessity – beginning in the emergency room and ending in the billing department. For this reason, each hospital department must help the hospital successfully manage the threats faced by the transition to a permanent RAC program.

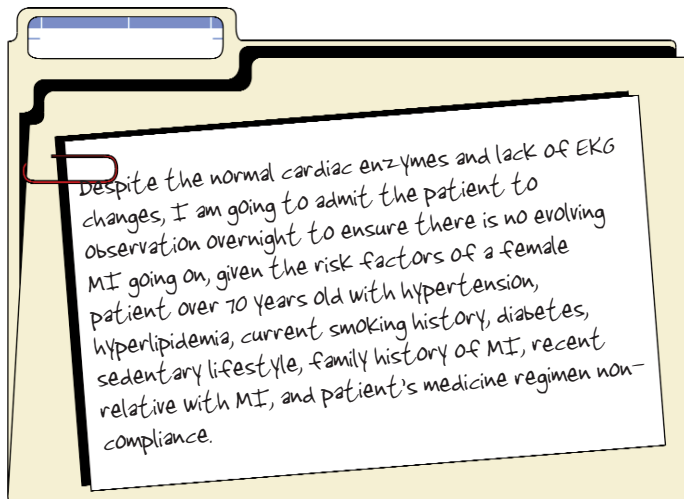


## Preparing Your Players

**ED nurses** must provide accurate and complete documentation of a patient's clinical acuity. This documentation must also clearly represent all nursing interventions and the patient's clinical

response (or lack thereof) to these interventions, when appropriate. Accurately documenting the patient's clinical acuity throughout the patient's ED course of care cannot be stressed enough in establishing medical necessity for inpatient admissions.

**ED physicians** must assess the patient and document all facts or assumptions that contribute to the medical decision-making process, specifically medical and family history. Here is an example of how a physician might effectively document the diagnosis of a 72-year-old female patient with a host of risk factors for MI, who was admitted through the ER with acute chest pain and admitted appropriately as an observation case:



**Attending and consulting physicians** must explicitly document their assessment of a patient in the history and physical paperwork. This includes details of the provisional diagnosis, risk stratification and discussion of clinical concerns, risk of morbidity and mortality, and a documented plan of care.

**Case managers** must guide physicians in determining appropriate patient status, as well as provide support and guidance to physicians on documentation – recognizing that RACs do not use Interqual criteria to determine medical necessity or “appropriate” patient status. A case manager must also recognize the need to confer with the department’s medical director, physician liaison or physician advisor about clinical scenarios in which established medical necessity for inpatient admission is questionable.

**Coders** must adhere to all official AMA CPT and ICD-9 coding guidelines and regulations. They must also understand the “clinical definition” of the

principal diagnosis and the concept of medical necessity as it relates to the principal diagnosis. A heightened understanding

and working knowledge of clinical medicine can be a coder’s best defense against the RAC. Coders need an ability to interpret clinical results, recognize common/obscure disease processes and seek clinical query clarification from the physician, as appropriate. **The “old school” thought process of “Gold Sheet” coding – where the coder reviews the medical record and converts diagnoses documented in the record into ICD-9 codes without incorporating a clinical coding thought process – will threaten the hospital’s financial survival under MS-DRGs, POA and the RAC initiatives.**

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A strong **billing** team must recognize questionable charging/coding and should become increasingly familiar with the charge capture and coding processes as they relate to billing. Billing must also be proficient at rebilling inpatient Medicare accounts as outpatient, as needed, after an inpatient denial by the RAC.

## Taking the First Step

Your hospital’s first step to prepare for the RAC is to identify each department’s strengths and weaknesses specific to the RAC program, and then develop and implement improvement processes to address weaknesses. Specifically, you must evaluate:

- ◆ The quality and completeness of medical record documentation from ER to discharge
- ◆ The clinical accuracy of all coding – from a RAC and MS-DRG standpoint (using PEPPER data as a starting point)

- ◆ The effectiveness of your case management/utilization review processes, including:
  - Inpatient vs. observation designation
  - Length of stay
  - Medical cases beginning as observation converted to inpatient status
  - Surgical cases beginning as outpatient surgery converted to inpatient surgery
  - One day stays, inpatient and observation that do not meet any reasonable criteria for hospitalization

## Clinical Documentation: Asking the Right Questions

As you consider clinical documentation in your hospital, it's important to consider:

- ◆ Does your hospital currently have a clinical documentation improvement program?
- ◆ If so, is the program effective? How is its effectiveness measured?
- ◆ Is your program a “coding improvement program” or a true “clinical documentation improvement program?” **A true clinical documentation improvement program captures the clinical documentation necessary to accurately report the patient’s intensity of service, severity of illness, risk of morbidity and mortality, and clinical outcomes.** The by-product of a clinical

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increased reimbursement. Contrast this with a “coding improvement program,” which focuses on obtaining the “medical record diagnosis buzz words” that lead to coding and assignment of a higher weighted MS DRG with higher reimbursement, vs. focusing on the legitimacy of the documented diagnoses from a clinical and compliance perspective.

- ◆ Is your clinical documentation improvement program ready to be taken to the next level? A top-notch program will incorporate clinical documentation improvement specialists that ascribe to the “business of clinical documentation” in their daily concurrent review of medical records, educational interactions with physicians, and efforts to seek clinical clarification from physician on any given record. **A cutting-edge clinical documentation improvement program focuses on continually educating the physicians about clinical documentation issues that impact both the physician’s and hospital’s interest in appropriate clinical outcome reporting and financial outcomes.** The underlying goal of a top-notch program is overall physician behavior modification in clinical documentation patterns, a win-win situation for the physician and the hospital.

## Coding vs. Clinical Coding

Coding accuracy does not necessarily equal clinical coding accuracy, which is required to successfully manage the RAC program. **Clinical coding accuracy requires that your coding staff has a reasonable understanding of medical necessity – and the knowledge and skills to recognize the difference between principal diagnosis and clinical principal diagnosis.** They must also know when to ask more questions, and how to construct a good query.

When evaluating your hospital’s clinical coding accuracy, look at how the results of your hospital’s PEPPER report compare to those of other hospitals in your state and region. You should also consider conducting a clinical coding review of the high-risk area MS-DRGs identified by the three RACs in the Demonstration Project:

- ◆ MS-DRG 291, 292, 293 Heart Failure and Shock with MCC, CC, No CC/MCC
- ◆ MS-DRG 551, 552, Medical Back Problems with MCC, without MCC

- ◆ MS-DRG 391, 392, Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders with MCC, without MCC
- ◆ MS-DRG 227, 228, Cardiac Defibrillator Implant W/O Cardiac Cath with MCC, w/o MCC
- ◆ MS-DRG 242, 243, 244, Permanent Cardiac Pacemaker Implant with MCC, with CC, without CC/MCC
- ◆ MS-DRG 640, 641 Nutritional and Miscellaneous Metabolic Disorders with MCC, without MCC
- ◆ MS-DRG 637, 638, 639, Diabetes with MCC, with CC, without CC/MCC

## The Review Process: Understanding Who's Looking at What, When and How

In addition to preparing for the permanent RAC program, hospitals must also plan for a transition of the medical utilization review process from quality improvement organizations (QIO) to Medicare fiscal intermediaries (FI) and Medicare administrative contractors (MACs); FIs and MACs will now be responsible for measuring and preventing improper payment to inpatient hospitals. FIs and MACs will perform medical review on either a pre-payment or post-payment basis to ensure that payments are for covered, correctly coded, reasonable and necessary services, and will conduct claim adjustments, as appropriate.

## Notification and Record Submission

The various review entities will utilize different means of notifying hospitals of an impending claim review.

- ◆ For purposes of measuring the error rate, a Comprehensive Error Rate Testing (CERT) contractor will notify providers that claims have been selected for CERT review via letter or telephone contact.

- The medical record request letter will be mailed or faxed according to the hospital's preference.
- Hospitals may submit medical records via mail or fax.
- ◆ For pre-payment review, the FIs and MACs will suspend claims for review and then send out a request for supporting documentation. A large volume of pre-payment reviews may prove to be a financial challenge and hardship to hospitals – especially smaller ones.
  - Providers may use the claim inquiry screen in the Direct Data Entry (DDE) system and verify the status of the claim. They may view the narrative for the reason code that is applied to a suspended claim. The narrative will provide the reason for the suspension.
  - Hospitals must submit hardcopy medical records via mail.
- ◆ For post-pay review, the claim is already paid. An FI or MAC performing post-pay review will send a request for medical records to the provider. The FIs or MACs will review the claim and make any adjustment necessary to the claim based on the review.
  - Hospitals must submit hardcopy medical records via mail.

## Screening and Review

- ◆ FIs, MACs and CERT contractors are required to use screening criteria in the review of acute IPPS hospital and long-term care hospitals claims, though CMS is not mandating the use of a particular tool.
- ◆ FIs, MACs and CERT contractors will also apply coverage, coding and medical necessity guidelines, utilizing clinical judgment in making payment determinations on each claim.

## Reviewers

- ◆ Qualified clinicians, such as nurses and therapists, will perform the reviews, consulting with physicians or other specialists as needed.

- ◆ As is the case with all other Medicare claim types reviewed by FIs, MACs and CERT contractors, there is no CMS requirement that physicians be used to review each acute IPPS hospital and long-term care hospital claim on which an adjustment may be made.

## Comparing Apples to Apples

Because of varying statutory requirements, there are some differences in the claim review processes used by various review entities. The following table provides a comparison of the processes used by the QIOs, CERT contractors, FIs, and MACs.

Issue	QIOs	CERT	FIs/MACs
Review selection	Random	Random	Targeted to claims with suspected improper payments. Initially, there may be some random review.
When the claim is selected for review	Post payment: 3 months after discharge	Post payment: Medical record request letter sent 35 days after payment	Prepayment: Shortly after the claim is submitted or post payment: <b>Up to 4 years after payment</b>
Credentials of reviewers	Qualified clinicians	Qualified clinicians	Qualified clinicians
Level of physician involvement in review process	Review all claims where non-physician reviewer identifies a problem with the claim	As needed, for complex cases	As needed, for complex cases
Use of coding experts	Mandatory	Mandatory	Mandatory
Distribution of Program for Evaluating Payment Patterns Electronic Report (PEPPER Report). This is a report containing hospital-specific data for 14 Diagnosis Related Groups (DRG) and discharges that have been identified as high risk for payment errors for every hospital in a QIO's state.	Mandatory	N/A	Undetermined
Use of Web-based application that allows providers to customize address and contact information	No	Yes	Future Web- based application would allow providers to see and update their practice location.
Reimbursement for photocopying medical records	Yes	No	No
Where to file initial appeal	QIO	FI or MAC	FI or MAC

## You've Been Reviewed. Your Claim Has Been Denied. Now What?

While having a successful clinical documentation improvement program is critical to managing the RAC, so is having an effective denials management program. **Such a program will help your hospital recover lost revenue, maintain regulatory compliance, and decrease costs by minimizing medical necessity denials, assisting in determining correct claim status and achieving appropriate lengths of stay.**

To make the most of your hospital's denials management program, assess it on a regular basis. Begin by asking these questions:

- ◆ What is the appeal overturn rate for your denials program – overall? medical? technical?
- ◆ What are the clinical knowledge and core competencies of the individuals responsible for appealing denials?
- ◆ Do you have additional staff to devote to denial appeals, if required?
- ◆ Do you have cross-trained staff to perform denial appeals, if necessary?

- ◆ Is your current methodology of tracking, trending and following denials and appeals effective and efficient?

If your appeal overturn rate is low or if you answered “no” to any of the above questions, then you could be leaving your hospital's money on the table and you should act now.

## Preparing for the RAC: Your Call to Action

Now that you have a better understanding of the RAC program and what it can mean for your hospital, you are ready to take the steps necessary to make your facility “RAC ready.” Begin by:

- ◆ Testing your hospital's state of readiness
- ◆ Identifying the root causes of vulnerability
- ◆ Developing and implementing process improvement plans that correct vulnerabilities
- ◆ Rapidly developing, implementing and staffing your RAC department infrastructure
- ◆ Building/enhancing skill sets of staff through focused education
- ◆ Refocusing adjustment and rebilling activities
- ◆ Validating/retesting the hospital's state of readiness

*From our work with clients in the RAC Demonstration Project states, QHR can help your hospital prepare for the permanent RAC program, so that risks are minimized and revenue integrity is maintained. QHR can help you avoid RAC denials by delivering practical process improvement recommendations and implementation assistance. We can also provide you with an effective process and the guidance necessary to win your RAC appeals. For more information on how QHR can help you manage the RAC, please contact Valerie Barckhoff, Vice President, Revenue Cycle, QHR at 800.233.1470, ext. 2046, or [Valerie\\_Barckhoff@qhr.com](mailto:Valerie_Barckhoff@qhr.com).*

To read more about how QHR has successfully helped clients address hospital issues, go to [www.qhr.com](http://www.qhr.com), and click on the Success Stories link.