RAC Forensics 101. Part 1: Medical Record Requests and the Discussion Period

By Sharon Easterling, MHA, RHIA, CCS

Thirteen months after the Recovery Audit Contractor (RAC) process was implemented nationwide, healthcare organizations are still learning how to best manage the audit process. The initial reviews were automated, but since that time RACs have also begun complex coding reviews and medical necessity reviews.

This is the first article in a series of three to discuss the RAC process from requests to appeals. The next article will discuss the provider portal, the discussion period, and review results letter.

RAC Tracking

Organizations should create and implement a tool to monitor and track the RAC process. A spreadsheet can be used, but it may not be practical or sensible because currently there are at least 90 data elements that are key to the process.

The ideal tracking tool has the ability to interface with hospital health information systems or the claims processor. This interface should capture more than encounter details and extend to charge detail of units, modifiers, visit codes, and condition codes. This level of detail is key to reducing RAC risk and implementing process change within an organization.

Unfortunately, most organizations don't have access to this type of system. However, many organizations have found success leveraging their IS departments to create a database using a common program such as Microsoft Access. This allows for easy data entry and the ability to run reports to track and trend data. It can be very cost effective and offer the provider the ability to capture data elements many other systems do not.

Organizations should keep in mind the volumes of information needed for the RAC reviews and determine what tool works best for them. Remember, RACs are not the only regulatory entities organizations must contend with. Implementing one system that tracks multiple audits would be of great value from a risk and compliance perspective.

Tracking Medical Record Requests

RACs can send only one request every 45 days. In order to stay on top of these requests, organizations should track all RAC requests for records. There can be errors in any process so it is an organization's responsibility to identify inappropriate and untimely requests.

So how should an organization set up an internal system to monitor and satisfy RAC requests? First, organizations should know their medical record limits, which is dictated by the Centers for Medicare and Medicaid Services. This cap limits the maximum number of records the RAC can request every 45 days and has a maximum of 300 records for providers, with a cap of 250 for durable medical equipment suppliers. There have been facilities receiving the maximum requests consistently since RACs began reviewing medical necessity.

Organizations should identify their current trends for requests to assist in making staffing adjustments for turning around requests and entering data into the tracking system. This will ensure organizations consistently address the demands of the RAC process. It also can provide a framework to help make process decisions related to the average number of records that can be successfully turned around within a specified time frame.

In terms of volume, a facility will receive only eight complex medical record requests in a 365-day period (excluding test claims); however, when a medical record request is received there is much work to do before retrieving the medical record.

First organizations should validate the list for inclusion in the list of approved issues posted by the RAC. This includes confirming the stated reason for review and the issue posting date. It is important that RACs request the correct issue and organizations send the appropriate request.

If there is a problem, organizations should contact the RAC. Phone calls are acceptable for communication, but e-mail is the best format to provide a record of the exchange. Organizations should follow-up if they have not received a response within 48 hours.

All contractors do not share a posting date so it's necessary to maintain an accurate list. Organizations should try to partner with a peer in their region or the state HIM or hospital association to make this tracking as easy as possible.

Next, organizations should confirm the patient's encounter information is correct. At times there may be differences in names due to marriage, birth date, divorce, et cetera. Organizations should check their internal systems from the HIM and billing perspectives because this information is obtained from the data exchanged between their fiscal intermediary (FI) or Medicare Administrative Contractor (MAC) and the contractor. If internal efforts come up short, the FI or MAC can provide direction.

Organizations also should take into consideration combined accounts or the 72-hour rule (three-day payment window). From a billing perspective these accounts are combined, but from an HIM perspective, these encounters are maintained as separate visits. To ensure the organization's billing is justified within the medical record, all documentation supporting charges billed for payment should be submitted.

Some records are bundled and some remain separate. According to a memo from the Centers for Medicare and Medicaid Services:

> Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission… As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient non-diagnostic services are unrelated to the beneficiary's inpatient admission.[1]

At times these services will affect DRG assignment. The record should be able to speak to the charges submitted and for which the organization received payment.

Ensuring appropriate documentation is not only important for combined accounts but also for documentation maintained in satellite departments. Contractors have cited chapter 6 of the Medicare Program Integrity Manual to provide further detail on medical review and what is needed to submit payments to Medicare:

> When the contractor determines that the beneficiary did require an inpatient level of care on admission, utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM coding guidelines to adjust the claim and pay at the appropriate DRG.[2]

Organizations should be sure their documentation speaks for the claim.

Medical Record QA

Organizations involved in the RAC demonstration project noted the importance of performing quality assurance (QA) on medical records when responding to requests. However, as the healthcare industry moves through a time of increased regulatory presence, many are grappling with the question of how much QA is enough.

A first step in the QA process is to ensure the organization has the basic documents requested by the RAC and to ensure the right person is validating this information. The type of request will and does affect who the right person for the job is. For example, outpatient audits may require a thorough review of charge details to ensure all documentation is submitted appropriately.

At the facility level, organizations should identify which individuals are most suitable in assisting in the QA process through trending and monitoring and implement training and adjustments accordingly. Organizations should use a checklist for requests and institute process change if there are issues.

Some factors that may also affect the process are the varied encounter dates the RAC may request. Incomplete records, including dictation and signatures, should be completed before they are sent to the RAC.

Organizations should implement a process to prioritize records that need completion to ensure RAC deadlines are met. Obtaining the appropriate information to complete a record is much easier than fighting a denial after the fact. It may be useful to review CMS Transmittal 327 CR 6698, "Signature Guidelines for Medical Review Purposes," to address common problems with signatures.

If a record has been denied because it was not complete or received in time, organizations should review the remittance advice code N102 and/or 56900. If there are justifiable reasons for not meeting a deadline, they can follow-up with the contractor, FI, or MAC. There may still be an opportunity to send in the missing documentation.

Paper versus CDs

The age of electronic health information allows healthcare organizations the ability to maintain and release information in a different way and provides a shortcut when trying to turn around volumes of data such as those requested by RACs. Organizations should discuss what format the RAC prefers to receive the information. CDs allow organizations to download PDF or TIFF files from their electronic systems.

Once a format has been identified, organizations can encrypt data, insert metadata files, and forward them to the RAC. Passwords for encryption should be coordinated with the RAC and sent separately.

Notes

1. Centers for Medicare and Medicaid Services. "Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window-Outpatient Services Treated as Inpatient." August 9, 2010. Available online at https://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf.
2. Centers for Medicare and Medicaid Services. "Medicare Program Integrity Manual." Chapter 6. Publication #100-08. Available online at www.cms.gov/manuals/iom/itemdetail.asp?itemid=CMS019033.

References

Centers for Medicare and Medicaid Services. "Medicare Claims Processing Manual." Publication #100-04. Available online at https://www.cms.gov/manuals/downloads/clm104c03.pdf.

Centers for Medicare and Medicaid Services. "Statement of Work for the Recovery Audit Contractor Program." Available online at https://www.cms.gov/RAC/downloads/Final%20RAC%20SOW.pdf.

Sharon Easterling (sharon.easterling@carolinashealthcare.org) is an assistant vice president for Carolinas Healthcare.

Article citation:
Easterling, Sharon. "RAC Forensics 101. Part 1: Medical Record Requests and the Discussion Period" *Journal of AHIMA* 82, no.1 (January 2011): 56-58.