RAC Ready: How to Prepare for the Recovery Audit Contractor Program

by **Kathy M. Johnson,** RHIA; **Allison Bloom,** MBA, RHIA; **Denise Morris,** RHIA, CCS; and **Rod Madamba,** RHIA

The Centers for Medicare and Medicaid Services is expected to announce the official start date of the Recovery Audit Contractor program this month, but it is already time for providers to be preparing for a potential audit. Managing a RAC audit effectively and efficiently requires preparing departments throughout the organization.

Form a Guiding Team

Organizations can get started by establishing a multidisciplinary RAC readiness and response team. The team should be charged with creating the goals, organizational structure, and operating processes for an ongoing RAC management program. Members will evaluate available RAC results to assist in planning and training.

The team should include representatives from patient financial services, the compliance department, office of general counsel, finance, and health information management.

The team needs a leader who is perceived as neutral, respected by all involved, thinks strategically, has a broad understanding of external and internal review processes, and communicates well. He or she will need these skills to create urgency, garner cooperation, and foster collaboration among a diverse group of individuals and departments, many of who will likely loathe devoting time and energy to a regulatory program.

The stakes are high. This is a good opportunity for HIM professionals to demonstrate their leadership capabilities and step up to take on the challenge.

Assess, Educate, Rally

As soon as possible, the readiness and response team should assess the organization's risk, educate senior leaders on the potential financial impacts, and alert those affected by the RAC program that their world is about to change.

The team needs to gain widespread participation and support for required changes in areas across the organization. Changes will likely range from implementing new policies and procedures for managing the response to RAC queries and denials to fundamental process improvement in the organization's documentation, coding, and billing practices.

Education of senior leaders should include the results of a thorough external review of coding, documentation, and medical necessity of past and present discharges. These results will help predict the potential financial impact, reveal any areas where documentation or coding education is needed, and identify medical necessity and patient status issues that need to be addressed. A review of one-day stays and the appropriate assignment of observation status are also important to round out the initial assessment of the organization's risks.

Developing a RAC management program may necessitate significant changes in revenue cycle functions, which requires the involvement of many key stakeholders. Along with the senior leaders, the guiding team should consider including education and action planning activities representatives from the following functions: case management, utilization review, and denial management, as well as medical staff services, admissions, billing and any areas involved in patient status determinations, clinical documentation, and medical necessity.

Finally, physician champions are very important relationships to cultivate from the beginning. Working together to improve documentation of diagnoses, procedures, and medical necessity will benefit all parties.

Centralize Management under HIM

Healthcare organizations are wise to centralize the management of RAC activities under the direction of HIM, so that skilled HIM professionals can receive, review, and coordinate responses to queries and denials, as well as track appeals.

Though accuracy of coding is one important aspect of the RAC program, the program is about more than coding issues. It touches several key areas in the facility not previously under scrutiny. The broader clinical data management expertise in the HIM profession is vital to the entire organization's understanding of and preparation for an effective RAC response process.

RAC Update

The RAC program is under an automatic stay due to protests over the four contracts awarded in October 2008. Two unsuccessful bidders for the program filed protests with the Government Accountability Office (GAO) the following month.

The automatic stay stops work for all four regional programs until GAO makes a determination. GAO has 100 days to consider the protests, making a decision due early this month.

Once GAO announces its decision, the selection process will likely be finalized and the expansion of the RAC program will be under way quickly. CMS officials have indicated that the implementation schedule will be compressed due to the delay.

For the Latest News

The CMS and GAO Web sites are helpful resources for the latest information on the RAC program:

- Centers for Medicare and Medicaid Services: www.cms.hhs.gov/RAC
- Government Accountability Office: www.gao.gov

Five Levels of Appeal

Level of Appeal	Deadline to File
1. Redetermination	Within 120 days from the date of receipt of the initial claim determination
2. Reconsideration	Within 180 days of receipt of redetermination (level 1)
3. Administrative law judge hearing	Within 60 days of receipt of reconsideration (level 2)
4. Medicare Appeals Council	Within 60 days of the receipt of administrative law judge decision (level 3)

5. Judicial review in US District Court	Within 60 days of the appeals council decision (level 4)

Prepare an Operations Team

Sarasota Memorial Hospital was part of the RAC demonstration project in Florida. There, an operational team of experts addressed the requests and denial process.

Ideally an operations team consists of staff from various departments with expertise and experience in processing requests and managing denials. Some of the recommended departments or experts to draw representatives from will already have been involved in the initial RAC readiness and response team. For example:

- Compliance, for regulatory knowledge
- Administration
- HIM, for the release of information and DRG and coding expertise
- Patient financial services, for billing information and tracking
- Case management, for medical necessity information
- Revenue integrity
- Charge master
- Medical staff

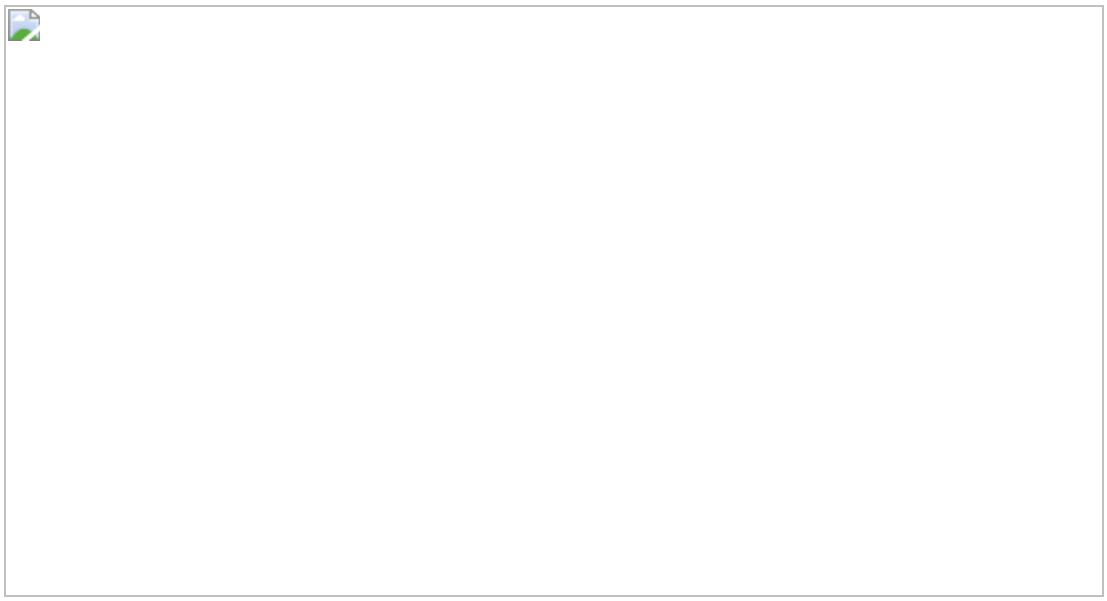
Sarasota's team met regularly and communicated with the organization's executive leadership. Good communication about the program throughout the organization cannot be stressed enough.

An important part of that communication is a dashboard report that summarizes the current status of RAC activities and their results. The report can include the number of requests received, the number of denials, the number of appeals by the stage in the appeal process, the dollar figure associated with cases in each level of the denials and appeals process, and the number of denials that have been overturned.

The team should be responsible for identifying and addressing trends in the types of requests, reasons for denials, or other relevant patterns that emerge over time. For example, is a specific physician or department, DRG, principal diagnosis, or procedure being targeted? Is there a trend that the organization needs to address through education, process improvement, policy change, or other means?

The RAC team should also be involved in ongoing education of the departments in the organization, including the medical staff, about RAC processes as well as issues identified through the program.

Tracking the Audit: Step 1



Learn the Appeals Process

Developing policies and procedures for the appeals process is another critical part of managing the RAC program. NYU Langone Medical Center, part of the demonstration project in New York, learned that the first step in a good appeals process is to make sure everyone understands the rights of the institution to appeal the contractor's decisions. Then a rigorous and tightly managed appeals process is needed to ensure the institution can take full advantage of the appeals allowed under the law.

The RAC program allows for five levels of appeal. The first opportunity in the appeals process is the informal **15-day rebuttal.** This is an optional step, not included in the five levels. While some hospitals have had success at this level, including Langone Medical Center, others in the demonstration project decided to skip to the first formal level of appeal, **redetermination.**

A redetermination appeal is generally made to the fiscal intermediary and has to be filed within 120 days. In the permanent RAC program, if the provider appeals within 40 days, recoupment will be postponed while the appeal is considered. Otherwise, the recoupment takes place, the appeal is filed, and the denial is upheld or successfully overturned.

To start the appeal, providers submit an appeal letter, which should be a review of the case including the medical justification for the claim. In addition, an appeal packet should include the RAC notice of denial and the remittance advice from the recoupment showing the date "harmed," if the recoupment has occurred.

The packet should also include a complete copy of the medical record. It is important to remember that copies are reimbursable at $0.12 per page. Staff should read the RAC letter carefully to ensure that the auditors are asking for the entire copy of the chart. Some auditors in the demonstration states asked that hospitals exclude certain documents, such as flow sheets and consent forms.

It is important to note the date of the denial to get the appeal to the fiscal intermediary within 120 days. The deadlines for hospitals to file appeals are strict. RAC auditors, however, have as long as they want to respond to an appeal.

Additional Levels of Appeal

If the redetermination denial is upheld, the provider's next option is to file the second level of appeal, which is called **reconsideration.** This is an appeal to the qualified independent contractor. Providers have 180 days from the first-level denial to file a reconsideration appeal.

The appeal for reconsideration should include the rationale for the first-level denial. Providers should respond to this rationale by providing supporting information or documentation to support the claim. The reconsideration appeal packet should also include the form letter sent by the RAC in the first-level response.

Providers should include the initial appeal letter, as well as the response to the fiscal intermediary rationale for upholding the redetermination denial. Providers must meet the 180-day deadline.

The appeal must be assembled in its entirety at this stage. After this appeal level, providers will not be able to present additional justification at higher levels unless they are able to show "good cause." For this reason, it is a good idea to have the reconsideration appeal reviewed by legal and medical experts before sending.

If the reconsideration denial is upheld, the third level of appeal is an **administrative law judge** hearing. Providers have 60 days to file the appeal. If the judge denies the appeal, the fourth level of appeal is to the **Medicare Appeals Council,** which must also be filed within 60 days of the preceding decision. The fifth and final level of appeal is judicial review in **US District Court.** This appeal also has to be filed within 60 days of the fourth level decision.

In 2008 the amount in controversy had to be at least $120 for third-level appeals and $1,180 for fifth-level appeals. The account incremental costs are increased annually by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers. There are no requirements regarding the amount of money in controversy for other levels of appeal.

No Time for Delay

Given that the program's current legal stay is expected to lift this month, providers are advised to complete their RAC preparations soon. Any improvements made now may avoid losses later. Given the significant sums of money recovered by RACs during the demonstration project and the current uncertain economic outlook, every penny counts more than ever.

RACs have motivation to move quickly, too. They cannot look back at claims that are more than three years old, thus every day that goes by without discovering and resolving an organization's vulnerabilities is going to result in a loss of revenue.

HIM professionals can provide the leadership required to initiate and implement a RAC plan that guides the organization's executives and the RAC response teams every step of the way, ensuring not only quality coded data but appropriate reimbursement.

Kathy Johnson (kjohnson@care-communications.com) is director of coding services at Care Communications in Chicago, IL. **Allison Bloom** (allison.bloom@nyumc.org) is director of HIM at NYU Langone Medical Center in New York, NY. **Denise Morris** (denise-morris@smh.com) is senior DRG coordinator at Sarasota Memorial Hospital in Sarasota, FL. **Rod Madamba** (rmadamba@stanfordmed.org) is director of HIM services at Stanford Hospital and Clinics in Stanford, CA.

Article citation:
Johnson, Kathy M; Bloom, Allison; Morris, Denise; Madamba, Roderick. "RAC Ready: How to Prepare for the Recovery Audit Contractor Program" *Journal of AHIMA* 80, no.2 (February 2009): 28-31.