Two Challenges for Here and Now: Grappling with RAC and POA Requirements

by Dan Rode, MBA, FHFMA

This column often deals with AHIMA's or the profession's larger goals and objectives. Important, yes, but often not what HIM professionals are involved with on a day-to-day basis. This article addresses two significant issues that HIM professionals are facing on the job right now.

The Medicare RAC Project

HIM professionals in California, Florida, and New York have been grappling with the Medicare Recovery Audit Contractor (RAC) project for several years now. Beginning this spring, more colleagues will join their struggles. CMS is in the process of expanding the program to all states between this spring and 2010.

The problem is that the pilot project has not gone smoothly. Facilities and hospital associations in the three pilot states are calling on CMS and Congress to stay the project, investigate current contractor processes, and establish or reinforce requirements for contractors. A proposed bill in Congress would enforce this delay and review.

Issues with Requests, Submissions, and Appeals

Undoubtedly, billing audits and chart audits are not new. More than a decade ago, AHIMA, in conjunction with other national payer, provider, and professional associations, was involved in the establishment of the National Billing Audit Guidelines at Congress's request. The 1992 guidelines address qualified auditors, auditor-facility communication, and audit scheduling. All three matters are at issue in the current RAC pilot.

AHIMA members in the RAC pilot states relay numerous examples of clinical and administrative challenges from the RAC pilot operations. Audits are conducted off-site (often called desk audits), and audit requests have often come to a single facility in the hundreds, if not thousands.

Facilities are requested to provide individually named health records and are given a limited period of time in which to respond. In some instances, facilities have been given extensions for producing the records (e.g., when sending to one or more off-site locations of the contractor), but facilities report receiving additional requests, including duplicates of original requests, during the extension period.

Facilities also find themselves attempting to respond to the record requests via electronic, paper, and hybrid systems, as well as archived records in various formats. Several organizations have found the costs of producing the records to be very expensive.

The process for submitting records to contractors varies. Florida's RAC has different locations for different audits; consequently, records are often sent to the wrong site, raising additional privacy and processing issues.

In the three states, contractors have zeroed in on reviewing medical necessity, rehabilitation services, and coding. Critics have reported that medical necessity reviews have often been done without appropriate clinical expertise and without a clear understanding of a facility's records. HIM professionals note that there is no such thing as a standard record and question desk audits performed without facility assistance.

RAC decisions to deny payment on the basis of medical necessity have been overturned on appeal. The appeal process, of course, requires additional work on the part of the provider.

That process can involve the RAC contractor and a facility's Medicare fiscal intermediary or quality improvement organization. While the initial appeal should go to the contractor, some have short-circuited this process and initiated their appeals directly to the intermediary. The time to appeal is limited, and facilities with limited staff have often let the denial and take-back occur, not having the resources to pursue the matter.

Coding audits for claims have varied. Some organizations have decided not to appeal certain ambulatory cases because the cost of doing so would be higher than the amount under consideration. In fairness, it must be noted that some providers have reported that the RAC process has caught errors the facility was not catching in its coding audit process.

Other concerns that arise over the RAC process include poor communication with providers regarding questions that arise during review and denials. (Many providers are surprised that there are not more questions, given the complexity of some records.) While it has been reported that some facilities were not aware of denials until the fiscal intermediary withdrew payment in a remittance advice, AHIMA has found that facilities were usually aware of the denial but the retracting of payments was not in sync with the denial process. Several facilities reported that in some cases no withdrawal took place.

Providers are also concerned with the means of recompense RAC contractors receive, citing commissions of up to 33 percent of the claims for denials and a lesser amount for situations where the contactor found that the provider had been underpaid.

Righting the RAC Course

The American Hospital Association has taken the lead in protesting the actions of the contractors engaged in the RAC pilot. AHA has also raised concern that some of the contractors have chosen to audit admissions or encounters that are several years old, older than AHA believes is warranted given the directions Congress provided when the auditing process was first required.

It must be clear that providers, AHA, and AHIMA are not protesting auditing of claims; they are protesting the audit process in the pilot states and the scope of work developed by Medicare to expand the RAC process to all states.

Given the questions and protests being raised, Representative Lois Capps (D-CA) has proposed a bill in Congress calling for a one-year moratorium on the RAC program and its expansion to other states. At the same time, the bill calls for the Government Accountability Office to investigate complaints and report back to Congress. AHIMA supports the Capps legislation and urges members and state HIM associations to seek support from their own representatives. We will continue to work with Congress, AHA, and CMS to resolve the issues surrounding this process.

Present on Admission

In addition to the new RAC requirements, hospitals in the Medicare program must now report present on admission (POA) indicators, effective October 1, 2007. The POA regulation is meant to exclude from payment services that are rendered to a patient due to a problem or condition that occurs in the hospital (i.e., that was not present on admission). The current Medicare regulation is limited to six situations.

Through the end of this month, CMS is providing feedback on reporting errors through remark codes on the remittance advice. Beginning April 1, CMS will return claims lacking correct POA information. However, actual payment denials will not begin until October 1 (on admissions after October 1). Medicare is promising more regulations in the spring Medicare IP-PPS notice of proposed rule making.

Hospital associations in several states have announced similar programs related to "never events"—serious, preventable errors in medical care. Hospitals in these programs have promised not to bill for care resulting from preventable events identified under standards developed by the National Quality Forum. Some health plans and payers have announced similar programs.

Reporting POA and never events reliably is dependent on the information received at the time of admission or transfer as well as information in the hospital record. It will require adequate documentation from physicians. HIM professionals will be a key source in identifying such events, as well as determining which charges might be associated with covered versus now noncovered services. HIM departments that have not prepared for these new programs should do so as soon as possible.

This is another situation that would benefit from a classification system richer than ICD-9-CM and an expansion in the number of classification codes accepted by Medicare and other providers. It is unfortunate that these programs have preceded US adoption of ICD-10-CM.

It is unclear just what refinements Medicare will introduce to POA reporting in May. AHIMA will continue to monitor and report on this requirement, as well as the issues that are moving states to take similar issues in the name of quality.

Upcoming POA Dates

April 1

Claims lacking proper POA reporting will be returned for completion.

May

More regulations expected in the IP-PPS notice of proposed rule making.

October 1

Payment denials begin on conditions designated in final PPS notices.

Dan Rode (dan.rode@ahima.org) is AHIMA's vice president of policy and government relations.

Article citation:
Rode, Dan. "Two Challenges for Here and Now: Grappling with RAC and POA Requirements" *Journal of AHIMA* 79, no.3 (March 2008): 18,20.