

# The RAC Attack:

Strategies and best practices to effectively manage  
Recovery Audit Contractors (RAC) - the newest  
CMS audit program

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## **The RAC Attack: Strategies and best practices to effectively manage the newest CMS audit program**

More than \$110 million in losses, cancelling the construction of a new academic medical center, discontinuing partnerships with two prestigious medical schools, rumors of layoffs, and a replaced CEO – they were all part of a dismal 2007-2008 economic picture for Boca Raton Community Hospital. One contributing factor to that picture – \$13.6 million in overpayment determinations through a pilot government audit program – the Recovery Audit Contractors (RAC) program.<sup>1,2</sup>

What kind of program could wreak such havoc and instill dread and fear into hospitals and other healthcare providers?

This white paper offers a synopsis of what every healthcare provider who submits Medicare fee-for-service claims should know about RAC. It also offers steps providers can take to identify and implement best practices across their organizations for managing the RAC process.

### **What is RAC?**

The Recovery Audit Contractors (RAC) program was created by the Centers for Medicare and Medicaid Services (CMS) in order to recoup Medicare fee-for-service overpayments and identify underpayments, RAC was launched in 2005 as a trial program. During the next three years, it expanded to include six states that all had high Medicare volumes: Arizona, California, Florida, Massachusetts, New York and South Carolina.

The trial program was initiated under Section 306 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, which directed the U.S. Department of Health and Human Services (HHS) to determine if independent auditors could successfully be used to identify payment inaccuracies.

Using proprietary software, audit contractors identified \$1 billion in potentially improper Medicare payments made between March 2005 and March 2008. Roughly 96% of the improper payments (\$992.7 million) were overpayments collected from providers and put back into the Medicare Trust Fund. The remaining four percent (\$37.8 million) were underpayments identified and paid to providers. Roughly 95% of the overpayment dollars recouped by Medicare came from hospitals.<sup>3</sup>

*The net result was \$693.6 million in improper payments returned to the Medicare Trust Funds between March 2005 and March 2008.<sup>3</sup>*

### **Why RAC Feels Like an Attack**

With such successful results, CMS is rolling the RAC program out nationally, and hospitals and other providers are struggling to prepare for the challenges ahead. Healthcare providers base their fear on the stories they have heard from hospitals in the demonstration states. For example:

- A 27-facility hospital system in Northern California, Catholic Healthcare West, is still appealing more than \$11 million in overpayment determinations.<sup>4</sup>
- Martin Memorial Health System, a 344 bed facility in Florida, reported that 2,570 cases were reviewed by RAC. The auditors found overpayments in 39.4% of the cases reviewed, resulting in \$3.4 million in take backs. Some 74.4% of those were for the incorrect utilization of inpatient services. The hospital has been able to have 21% of its claims (211 claims) overturned on appeal, but 203 claims are still pending appeals.<sup>5</sup>
- MemorialCare Health System, a 1,500-bed non-profit hospital health system in Long Beach, Florida, found itself with 1,148 claims modified by the auditors, but was able to recoup \$2.5 million in overturned claims in the appeal process.<sup>6</sup>

In addition to the high cost of potential lost revenue due to RAC overpayment judgments, hospitals are also concerned about the costs of managing the process, the high volume of records requests, and the stringent deadlines associated with the program. Most healthcare providers have been preparing for and seeking RAC solutions from a variety of sources: internal teams, outside vendors and upgrades to existing processes and procedures. Healthcare providers can take a number of steps to properly prepare for the RAC program's arrival in their state. And even facilities that are already undergoing RAC scrutiny can make adjustments to their procedures to employ best practices for better results and revenue integrity.

### **Preparedness**

RAC preparedness has been the topic of discussion throughout the healthcare community for the last few years, and as the rollout to additional states continues, healthcare enterprises can take several steps to prepare. In a recent survey of health information professionals, MedPlus found that:<sup>7</sup>

- 87% had formed a RAC team
- 74% had begun defining policies and procedures

- 63% had seen a software demonstration
- 26% had purchased a software solution<sup>7</sup>

A healthcare enterprise can undertake a series of strategic and tactical initiatives to complete their RAC planning. Organizations that have already begun planning should consider these best practices and incorporate adjustments to implement an effective RAC solution.

### **Build an Internal RAC Team, Including Physicians**

Hospitals and other healthcare providers are best served by organizing a RAC Task Force, an interdisciplinary response team that can coordinate efforts across the organization. The team should include representatives from:

- Compliance
- Coding/HIM
- Case Management
- Revenue Cycle
- CFO
- Patient Accounts
- Physicians

Providers should also create or designate a RAC Coordinator responsible for overseeing the process and ensuring that team members are responsive and meeting deadlines.

Physicians should be an integral part of the RAC team. It is their expertise that helps to determine which overpayment judgments the organization should appeal. They should be involved early in the process because no new paperwork or evidence can be introduced beyond a Level 2 appeal.<sup>9</sup>

Providers are finding success when physician opinion, including the assessment of the prior history, vital statistics, at-home care circumstances, and the standard of care comes into play. Especially in situations relating to length of stay and medical necessity, a technically-written physician opinion is vital.

Level 3 appeals are heard by an Administrative Law Judge, a non-medical jurist. A physician's technical explanation of the reasons for a procedure or length of stay provides educational background that the judge may find useful. One hospital reported an 81% overturn rate on their third level appeals.<sup>6</sup> The AHA estimates that healthcare organizations can spend between \$2,000 and \$7,000 to file a RAC appeal.<sup>10</sup>

### **Establish one location for receipt of RAC requests**

In a recent presentation, Marcia Matthias, Corporate HIM Director and Privacy Officer for Southern Illinois Healthcare, suggested that hospitals should rent a post office box exclusively for the receipt of RAC requests. She also recommended that hospitals contact their RAC agency to see if they will send a test RAC document to a specified address.

Marcia's organization had one test document sent to the hospital at the same time a test document was sent to the post office box. It took two days for the RAC coordinator to get the test letter from the post office box; it took two weeks for the RAC coordinator to receive the test sent to a regular hospital address.

With only 45 days to respond, hospitals may not be able to afford to lose days or weeks waiting for RAC requests to go through normal hospital mail channels.<sup>17</sup>

### **Identify and Document Workflows**

With your RAC team in place, it's recommended that team members develop and communicate processes and procedures for receiving, processing and tracking requests, and managing the appeals process. A successful RAC system will provide a streamlined system for release of information, concurrent reviews, and input from the RAC team, and maintain a record of the RAC request along with which specific versions of which documents were released.

In a survey of health information professionals, 68% of the respondents indicated that coordinating multiple reviewers was one of their biggest RAC challenges. They also ranked not missing deadlines (53%) and releasing the medical record (38%) as substantial challenges.<sup>7</sup>

The way in which to mitigate that is to seek and install a fully-integrated system that allows access to all relevant records, including the medical legal record, billing, labs, radiology, and other departments' reports and documents.

Requirements for that solution should include:

- Automatically route reviews to RAC team members
- Provide concurrent reviews by RAC team members to fit within the 45 day deadline
- Instill automatic timers, alerts, and deadline reminders for team members
- Track RAC request status
- Record which versions of which documents were disclosed and to whom
- Attach additional documents beyond the records request, based on the opinions of the team
- Generate an invoice to bill a per page fee for release of information

- Automatically number the pages of the released documents
- Track the delivery and receipt of the RAC response package and follow-up on subsequent deadlines

### **Follow Data Trends**

Making informed decisions about the strategy for responding to RAC requests is of vital importance. With limited staff and resources, providers must choose their battles when determining which RAC determinations require appeal. To prevent overpayment judgments in the first place, RAC team members must be able to compile complete documentation and information that puts each claim in the best light.

A useful RAC system should allow the RAC team to:

- Self-audit, reviewing charts with the same criteria established in RAC review descriptions
- Assess vulnerability and risk by running reports on target DRG codes
- Evaluate the number of records requests in the RAC process and their current status
- Record the successes and failures in appeals, reasons for judgments and rationale for overturning them
- Report the productivity of the RAC team to identify bottlenecks and the need for additional resources

Data reporting was also a chief concern among health information professionals. Of those who responded to a recent MedPlus poll, 68% said collecting and displaying meaningful statistics was a RAC audit challenge.<sup>7</sup>

### **Modify Policies and Procedures**

Disciplined RAC teams should have systems in place for correcting identified errors in procedure, documentation, or coding. Utilizing good reporting and data trends, RAC team members can implement changes and deploy new best practices throughout their organization to begin to reduce errors.

Identify root causes of these compliance errors, including:

- Clinical documentation errors and omissions
- Case management process shortcomings
- Coding staff repeat mistakes

By identifying systematic problems, hospitals can take a two-pronged approach in their RAC process:

- First, recognize the mistakes of the past, and assemble common defenses for multiple claims with a similar overpayment determination. By evaluating the dollars at stake and the likelihood of success, hospitals can prioritize if and when these kinds of claims will be appealed and have rationale and defenses ready to attach to these appeals.
- Second, the organization can create solutions to prevent future overpayment errors by correcting problems. A comprehensive RAC system will allow for customizable alterations to record-keeping and processes to make compliance with changes easier to implement and enforce. Enhanced documentation requirements for physicians, coding policy corrections, and/or altered patient policies can be among the prevention answers.

For example, an academic medical center with 1,500 beds in New York experienced a common RAC overpayment judgment, for the incorrect coding of debridement. They received judgments against “excisional debridement” claims that didn’t include a physician’s documentation that a surgical debridement occurred.<sup>8</sup>

Although coaching a physician to document for the purposes of coding is improper, an organization may prompt a physician to be complete in his procedure explanation. They may require physicians, for example, to indicate whether a procedure included the surgical removal or cutting away in an excisional debridement as opposed to a mechanical debridement with brushing, scrubbing, or washing.

With this more complete information, the medical coder is able to properly code and bill for the correct procedure with supporting documentation, protecting it against a common overpayment judgment. Across the demonstration project, RAC overpayment judgments on this coding issue – excisional debridement – resulted in \$66.8 million in repaid funds to the Medicare Trust Fund.<sup>3</sup>

### **Self-reporting**

While self-audits for Medicare claims and self-reporting of any errors that are discovered are good practices in general, there may be added benefit to performing these tasks now that the RAC program is in place.

Because Recovery Audit Contractors receive a commission for their successful overpayment judgments, they are likely to target hospitals and health systems

they see as vulnerable. One potential benefit of self-reporting errors could be to minimize your vulnerability to RAC audits. In addition, for some claims, hospitals can re-bill claims requiring correction of coding errors if the hospital self-reports, but if the RAC auditor discovers the error, the hospital may only be allowed to re-bill for ancillary services.

And while the funds are required to be returned to the Medicare Trust Fund and there is no discount for self-reporting, amended claims can result in recovered dollars compared to overpayment judgments, which can result in an all or nothing win or loss.<sup>11</sup>

Regardless of the type of self-audit, it is never a good idea to ignore an improperly filed or incomplete claim. Whenever an error is identified, providers should make the correction.

Hospitals with a history of self-reporting errors may develop a reputation as infertile ground for RACs, and thereby avoid an abundance of records requests and overpayment judgments. And by eliminating easy wins for auditors, a hospital might reduce the number of records requested.

Some hospitals also adopt this self-reporting strategy out of principle, as one compliance officer at a large western hospital system said, “We resubmit claims where we find errors because we would rather see our money go back into the Medicare Trust Fund than into the pockets of the RAC auditors,” as quoted by a medical industry research team studying the RAC demonstration project.<sup>8</sup>

### **Deadlines**

Failure to respond to the initial records request within the crucial 45-day deadline results in an automatic technical denial. The RAC can then recoup those Medicare Funds without showing cause, and providers have no opportunity to appeal. Deadlines within the appeal process are also important. In appeal cases during the demonstration project, the RAC judgment was automatically affirmed if a provider missed an appeals deadline.<sup>12</sup>

These deadline issues can become especially tricky as providers are confronted with mounting numbers of cases. CMS recently announced a new formula for determining a total on the number of RAC requests a provider can receive.<sup>13</sup>

First, the cap would apply to each “campus” of a hospital or healthcare network. A campus is described as one or multiple physical locations operating under the same Tax Identification Number within a similar zip code (the first three digits of the zip code must be the same). Locations within the same network, sharing a

Tax Identification Number but with different zip code 3-digit beginnings would be considered separate campuses and have two different limits on RAC requests.<sup>13</sup>

Once the campus is identified, CMS will calculate that campus' limit for the number of RAC requests it can receive per 45 days. The calculation begins with 1 percent of the campus' total of all claims in the previous calendar year, regardless of claim type and including professional services. That amount will be divided into 8 periods of 45 days each. The RAC can then request that many records per 45 days.<sup>13</sup>

There is a universal cap through March 2010 for each medical campus of 200 records requests per 45 days. No campus' total will exceed that amount per period. But from April 2010 through September 2010, that universal cap will be remain the same for smaller providers, but will be 300 records per 45 days for campuses that have an excess of 100,000 claims to Medicare.<sup>13</sup>

The new guidelines also note that the composition of the records requests – how many are for inpatient, outpatient or professional services – is at the RAC's discretion and not limited to the percentage of the medical enterprise's business in that category. If the RAC wants to use the entire quantity of the limit on inpatient claims, it can do so even if inpatient claims represent only 15 percent of the provider's total business.<sup>13</sup>

But some medical providers may find themselves outside these guidelines, facing additional requests. After the first six months of the fiscal year, RACs may request permission from CMS to exceed a campus' cap. CMS will decide this on a case-by-case basis and notify providers before they begin receiving these additional requests.<sup>13</sup>

Once the 45-day period expires on a record request, another record request can be submitted in its place. Record requests in the appeals process do not count toward the total maximum, so some providers can be responding to and tracking requests, records, and appeals for thousands of claims simultaneously.

Deadline alerts and reporting are vital to any efficient RAC solution. Many of the demonstration projects report attempting to track their cases on simple spreadsheets, but found it difficult to keep up. Tools that provide visual cues, e-mail reminders and other alerts to RAC team members provide the greatest opportunity to consistently meet deadlines and avoid technical denials and automatic overpayment affirmations.

## Appeals

The RAC program does allow for providers to appeal to alternative authorities when they feel an overpayment judgment is unjustified. These appeals occur over several progressive levels:

- Discussion period allows for rebuttal to the RAC within 15 days (optional)<sup>9,14</sup>
- Level 1 appeal to Fiscal Intermediary within 120 days
- Level 2 Appeal to Qualified Independent Contractor within 180 days of Level 1 finding
- Level 3 Appeal to an Administrative Law Judge within 60 days of Level 2 finding
- Level 4 Appeal to the Medicare Administrative Contractor within 60 days of Level 3 finding
- Level 5 Appeal to the District Court within 60 days of Level 4 finding<sup>9,14</sup>

Appeals can cost between \$2,000 and \$7,000<sup>10</sup>, and appeals requiring intensive legal review, physician comment and opinions can continue to escalate in cost. Effectively appealing RAC decisions is a chief concern of health information professionals, with 68% of them reporting that task as one of their biggest RAC challenges, according to a recent survey by MedPlus.<sup>7</sup>

The best RAC system will provide data-based intelligence on claim status and an organization's success in appeals. Organizations can spend their appeal resources focused on appeals of claims with a high success rate and/or high dollar value involved in the claims. Or, providers can choose to appeal a claim because it has implications for a large volume of additional claims. With proper data, an organization can understand the greatest opportunity to recoup dollars and receive a return on their investment in appeals.

Data trend tracking can also provide clues into patterns for winning arguments. Some successful arguments for appeal from the demonstration project include:<sup>4</sup>

- No published Medicare criteria to support the overpayment determination
- The "provider without fault" doctrine
- Improper review, asserting that the RAC misunderstood medical necessity of a procedure<sup>4</sup>

Some demonstration project providers have made an overarching argument that the program violates constitutional due process because the RAC has a financial incentive to make overpayment judgments. So far this argument has not produced results.<sup>15</sup>

Appeals also present the opportunity to provide additional documentation that might not have been included in the initial response to a RAC record request. But hospitals must remember that no additional documentation can be provided beyond the Level 2 appeal.<sup>9</sup> Any information provided at that time becomes the official record for future appeals. It's imperative for records managers to be able to confirm they are releasing the most current and most complete records at any given time. With a comprehensive medical legal record system, compiling this record should be easy. Intelligent release of information programs provide complete tracking of all record releases and the rationale for each release.

Anecdotally, hospitals are sharing that they are seeing the most success at the Level 3 appeal to the Administrative Law Judge.

### **The Future of RAC**

Hospitals and other healthcare providers can expect that RAC is here to stay. They should also be on the lookout for its expansion beyond Medicare.

Commercial payers are also evaluating the effectiveness of post-payment reviews. In New Hampshire, a 400-bed hospital received a demand for records for 300 paid claims from its largest private payer to review them for potential errors. And in Georgia, commercial payers have hired post-payment review specialists to audit closed claims searching for coding errors and medically unnecessary procedures.<sup>8</sup>

One of the RAC agencies, Connolly Consulting, already counts four of the six largest commercial payers on its client list.<sup>16</sup> And some hospitals are sharing that their commercial payers are employing RAC-style procedures to review similar RAC-focused DRG codes and criteria.

Can commissioned auditors from Medicaid and commercial payers be far behind?

Providers are best served by addressing these RAC issues now. Customizable solutions may be required to meet this demand. And by implementing scalable systems that can accommodate a large volume of requests, providers can prepare for this future.

Imagine receiving 400 records requests from Medicare, 300 records requests from your largest commercial payer, and 100 requests each from your next three payers. Could you handle the workload? Do you have systems in place to standardize and streamline your workflow, manage your deadlines and navigate the appeals process? Now is the time to act!

### **About the Authors**

MedPlus® has more than fifteen years of proven experience in solving medical records challenges - from the moment that the patient registers to managing, overcoming, and overturning insurance denials. ChartMaxx®, the document management and imaging solution from MedPlus, has solved the key problems that revolve around the legal medical record, and is enhancing its features in the latest version, ChartMaxx 5.5, to support organizations as they contend with the RAC program. ChartMaxx's fully-integrated RAC Solution supports organizations through workflow management, streamlined ROI (Release of Information), Intelligent eForms, executive dashboards and other reports to ensure leadership teams can assess risk and make data-based decisions about RAC records requests, overpayment determinations and appeals.

To learn how MedPlus and the ChartMaxx solution can help your organization, visit [www.medplus.com/RAC](http://www.medplus.com/RAC) or call 800.444.6235.

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