



RAC Lessons Learned

Recovery Audit Contractors – Lessons Learned

The 2010 nationwide expansion of the Recovery Audit Contractors (RAC) Program started slower than many anticipated. Facilities feared immediate medical necessity reviews of large numbers of records with large recoupments. Vendors fueled the concerns of an immediate onslaught of recoupments and stressed the need for substantial investments in tracking software and infrastructure expansion to manage appeals. The focus for many facilities was placed on preparing for the defense of the recoupment effort by the RACs, rather than the operational details of concurrent processes to ensure CMS compliant billing. Some facilities find relief in the relatively slow and somewhat benign roll out of the RAC program beyond the demonstration project. However, the following five lessons from the demonstration project and from 2010 activity suggest that any quiet on the audit front should be used wisely to proactively make storm preparations:

Lesson 1. The Fundamentals Matter. Facilities need clear admission orders, signed and dated by physicians. “Admit for observation” is an order for an inpatient admission, not for observation level of care. “Admit to observe the patient overnight” is also likely to be viewed as an inpatient order not supported by medical necessity since the order implies no intensity of service anticipated beyond observation. Hospitals work on educating staff, but avoiding ambiguous level of care orders requires concurrent processes to address ambiguities at the time care is delivered.

Lesson 2. Do It Now, Not Later. Concurrent processes are necessary. Many of the billing dilemmas exist because of poor concurrent documentation. Level of care orders cannot be changed when the patient is discharged. The date and time of orders is critical. The clarity of the content determines what can be billed. All of these items should be addressed through concurrent documentation processes so that documentation is complete and accurate. Retrospective review can identify issues but only concurrent processes can prevent the problem.

Lesson 3. Because They Built It, They Will Come. Every facility will be affected. The constant refrain in the discussions about how to finance health care reform was that there is too much fraud, abuse, and waste in the system. With almost a billion dollars recovered in the demonstration project, the government

received affirmation that billing errors are rampant. The use of contingency fee paid auditors gives the auditors an economic incentive to cast a wide net and move aggressively. In the demonstration project, facilities recounted experiences of a few intermittent requests at the beginning of the project with increase in frequency and volume of requests at the end. The project is rolling out; expect acceleration throughout the year.

Lesson 4. No Substitutes: Use the “Real Thing”. There is no substitute for physician documentation supporting clinical decision-making. Appropriate clinical decision-making is fact specific; therefore, if reimbursement is dependent on physician clinical determinations such as whether a service is “medically necessary” or whether there is a “related diagnosis” well documented physician rationale should be dispositive when it conflicts with a non-MDs application of evidence based criteria. Contrary to information provided by some FIs and MACs, CMS guidelines specifically reference and defer to the attending physician’s judgment not commercial evidence-based criteria.

Lesson 5. Color Between the Lines and Make Sure the Lines are Visible. The RACs and the government change the areas of review, the rules applicable for reimbursement and interpretations of those rules. RACs are uncovering areas where guidance is unclear or contradictory (such as the 72 hour bundling requirement). To determine whether to appeal a recoupment, one important question is whether there was a billing error based on the rules that were applicable at the time the service was performed and billed. Retain rules, guidelines, criteria, and guidance from the MAC and FI training/education material so that there is no recoupment based on inappropriate application of standards. The government defines the lines; keep copies of the schematic so when the picture changes, you have the original.

The reimbursement issues are complex and audit activities are pervasive. As with any complex activity, build a strong foundation paying attention to the details of the plans, who is doing the work, and what is happening each day. Don’t cut corners. Do it right. When buffeted by the storm of audits, you may find weaknesses, but a well built, well inspected and constantly maintained foundation and structure will provide protection against the audit storm.

**- Joan C. Ragsdale
CEO, MedManagement, LLC**

Joan C. Ragsdale, J.D. is the CEO of MedManagement, LLC. Ms. Ragsdale can be contacted at 205-970-8804 or jagsdale@medmanagementllc.com.