

Gearing Up for RAC

A third-party audit can help your organization breathe easier as RAC program implementation approaches.

By Michelle Martin

Improperly prepared claims strip badly needed resources from both the health care facilities that submit them and the agencies who review them. In an effort to reduce and eliminate such claims, the Centers for Medicare and Medicaid Services (CMS) are moving forward with expansion of the Medicare Recovery Audit Contractor (RAC) program. With the final implementation of the national RAC program required by 2010, health information executives must prepare now for the inevitable RAC audit.

Many facilities have now begun to look at elective or pre-RAC audits by independent professionals to proactively prepare. Through a pre-RAC audit, a third-party auditor analyzes a facility's Medicare claims and identifies areas where the CMS typically look for compliance issues related to medical necessity, documentation and coding.

Many health care consulting firms offer pre-RAC readiness services to help facilities prepare for RAC audits. Health care consultants, typically involved with the RAC demonstration project since it began in 2005, know the areas where RACs look for mistakes, can share RAC best practices, and show staff how to avoid common errors. In addition, they can compare a facility's data with known RAC targets and identify the cause of incorrect payments so staff can correct the issues prior to an audit.

Third-party auditors can also advise staff on managing RAC requests when they come in and provide guidance on RAC requirements, as well as the ins and outs of the appeals process. Consultants can also help health care providers create a team-based RAC task force and response plan, drawing on key players from departments such as Health Information Management (HIM), Case Management, Compliance, and Finance.

RAC target areas

A major focus area for RACs during the three-year pilot project in California, Florida, and New York was medical necessity. Sixty percent of all denials occurred in this area. RACs commonly check admitting documentation for medical necessity criteria, and review claims to determine if the patient met industry standard severity of illness (SI) and intensity of illness (IS) criteria. High-frequency, one-day-stay inpatients with a principal diagnosis of chest pain, syncope, congestive heart failure, dehydration, gastroenteritis, and elective cardiac pacemakers/implanted defibrillator procedures and PTCAs were reviewed for possible outpatient status. Additionally, RACs focused on accounts for a three-day qualifying acute care stay before being discharged to a skilled nursing facility (SNF) and/or swing-bed status. If the admission of three days does not meet the CMS' medical necessity criteria, claims for both the acute care admission and the SNF and/or swing-bed stay will be denied.

Some of the diagnoses that carry a risk of being deemed not medically worthy of a three-day stay include: failure to thrive, lethargy, altered mental status, weakness, dizziness, fatigue, headache, abdominal pain and any condition found in Chapter 16 of the ICD-9-CM coding book. These conditions are considered nonspecific and, after a three-day stay, more documentation on the patient's condition must be added to his or her chart. It's critical to make sure documentation is specific enough to warrant admission to an SNF and/or swing-bed status.

In addition to medical necessity, the selection of proper discharge status codes is a key area for RACs. To ensure a discharge status code is accurate, staff must follow up with any Medicare patient who was discharged home or to an SNF or HHA within three days to make sure the patient has not been transferred or admitted to another facility. RACs use the Common Working File (CWF) to track patients across health care settings for discharge disposition validation. They look at the acute care facility's discharge disposition, and reconcile it with any episodes of care performed within three days by another provider. As a best practice, hospitals should implement the same practice. Often, after a patient is discharged home, his or her family determines he or she requires assistance and seeks placement in a SNF, or home health services.

After taking the necessary steps to understand risks and effectively prepare for RACs, health care providers can breathe easier as full-scale implementation of the RAC program approaches. Providers that have properly prepared staff for a RAC audit will feel confident knowing they have the training and knowledge to decrease the likelihood of repeated RAC audits and consequent revenue loss.

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