



RAC Audits: Is Your Organization Ready?

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Background

In order to identify and prevent waste, fraud and abuse in the Medicare system, Section 306 of The Medicare Modernization Act of 2003 established the Recovery Audit Contractor (RAC) program as a demonstration program. This three-year RAC demonstration program took place in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration program resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly \$38 million in underpayments returned to health care providersⁱ. The Tax Relief and Healthcare Act of 2006, Section 302 required a permanent and nationwide RAC program by no later than 2010ⁱⁱ.

To summarize the program, RACs will review claims on a post-payment basis and there will be two types of review. In an automated review, no medical record will be required. In a complex review, the medical record will be required. Additionally, RACs will not be able to review claims paid prior to October 1, 2007. However, going forward, RACs will be able to look back three years from the date the claim was paid.

Claims reviews will be conducted by RAC contractors. Hospitals in each state will be assigned a RAC contractor, depending on their assigned regionⁱⁱⁱ. All RAC contractors are required to have the following individuals on staff: nurses, therapists, certified coders and a medical director. RAC contractors are paid for their work depending on a contingency fee for claims recovered.

This research was designed to address a number of issues, including the process that hospitals use to prepare for RAC audits; how prepared they believe they are to deal with audits; the use of software to manage the RAC audit process; challenges that exist with the current process; and who is responsible for coordinating the RAC audit.

Methodology

In order to answer these questions, HIMSS Analytics conducted a series of in-depth interviews and focus groups with individuals who were familiar with the RAC audit process at their organization. A total of five in-depth interviews and three focus groups were conducted in January and February of 2010. A total of 22 individuals participated in the in-depth interviews and focus groups.

All individuals who participated in this research worked for a hospital that has a minimum of 150 beds. In addition, to ensure that individuals were qualified to speak about RAC audits, they had to be either a decision maker or a decision influencer for their department. They also had to have a high level of familiarity with RAC audits that included one of the three roles identified below:

- I am ultimately responsible for this process
- I report to the person who is responsible for this process
- I sit on a committee that handles RAC audits

Individuals who reported having no knowledge of this process were eliminated from this project. By title, the respondents to the survey included a variety of finance and compliance titles, including Chief Finance Officer/Vice President of Finance, Director of Patient Finance Services, Director of Revenue Cycle Management, RAC Coordinator, Compliance Officer and Vice President/Director of Compliance. To ensure that we were getting a wide variety of responses in this research, we included both individuals who had been through a RAC audit and those who had not. At final count, nine of the respondents had been through a RAC audit; 13 had not.

Importance of a RAC Audit

Most of the respondents participating in this research indicated that their organization places a very high emphasis on the RAC audit process. On a scale of one to seven, where one is not at all a priority and seven is a high priority, survey respondents noted an average score of 6.40. Nearly all of the respondents mentioned that their primary concern about this process is the financial impact this audit can have on the bottom line of the healthcare organization.

The primary concern raised by respondents was the money that is at risk and the overall fiscal health of healthcare organizations. One respondent who works for a 500-bed facility that was audited in the demonstration period noted that they had to give back nearly \$1 million, and although they got nearly all of it back in the appeals process, it was a long, arduous process. Another respondent, who works for a healthcare system with 350 beds, estimated that their final take back after the demonstration process was \$2 million of the \$10 million originally identified. Another respondent estimated her risk to be nearly \$6 million, which if it all had to be paid back would wipe out the organization's bottom line.

“There is just so much money at stake. It’s basically millions of dollars of potential pay back to the Medicare program”. Mark Cocorullo, Senior VP & Chief Financial Officer, Martin Memorial Health System

Another concern is that the RAC audit process looks retrospectively at claims that have already been submitted and paid, dating back to October 2007. This means that in many instances claims that are disputed will involve money that has already been spent. And, since the repayment will be taken out of the current payments, those faced with repayment will see a dip in current revenue streams.

“There’s concern about money that would need to be paid back because they go back so far. It’s not like we’re looking at proactively going forward and saying we’re going to apply these things now. They’re going back to 2007 and its water under the bridge with nothing we can do about it now”. Susan L. Cresswell, Director, Quality Resources, Providence Medford Medical Center

Also of concern to these respondents is the potential ripple effect these audits will have on other payer organizations and insurance companies, which could compound the financial impact and liability healthcare organizations would face.

Several respondents also noted that they prioritized the RAC audit process so that they could ensure compliance with the timing requirements outlined in the process. However, for all of the respondents, the importance of compliance was a consequence of ensuring the organization met the required deadlines so that the organization would not be impacted financially.

Preparing for a RAC Audit

To prepare for the start of the program, Medicare has recommended a series of steps that they recommend organizations take to prepare for the RAC audit process. These steps include^{iv}:

- Identifying where improper payments have been persistent by reviewing the RACs' Websites and identifying any patterns of denied claims within their own practice or facility.
- Implementing procedures to promptly respond to RAC requests for medical records.
- If the provider disagrees with the RAC determination, filing an appeal before the 120-day deadline.
- Keeping track of denied claims and correcting these previous errors.
- Determining what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future.

This research also tested the steps that organizations are taking to ensure readiness for the national RAC audit program. Concerned about the substantial financial impact to their organizations, all respondents have noted that their organizations have taken formal steps to ensure accurate and efficient handling of the RAC process.

First and foremost, nearly all respondents have indicated that they have put a formal process into place that includes individual(s) to coordinate this process. This enables organizations to track the audit from the time their organization received the initial audit letter to the process of adjudicating the appeal, if required. A number of respondents also reported that they purchased a software tool that can be used to help manage the process of tracking the audit from the beginning of the process to the end, managing tasks such as tracking what status the audit is in and issuing alerts and reminders. However, as several respondents noted, the presence of a software solution isn't going to completely mitigate human intervention, because individuals will still need to sit down and manually go through the records.

Respondents also noted that evaluating their current environment is part of their process. This might include pursuing a mock audit process or evaluating their risk. For some respondents, this involves sending themselves a "mock" audit letter and evaluating how the process is working. For instance, was the initial letter routed to the correct person or is the organization having specific issues with specific steps of the process. Other respondents reported that their organization has hired external organizations, such as [The Advisory Board Company](#) or [Executive Health Resources, Inc. \(EHR\)](#), [The Physician Advisor Company™](#) to more formally evaluate the potential risk faced by their organization.

Despite the preparations already taken, respondents still have concerns about their level of preparedness. On a scale of one to seven, with one being not at all prepared for the audit process and seven being highly prepared, respondents recorded an average score of

5.67. The primary concern identified about handling a RAC audit level was simply the unknown; not having been through the process before, respondents were unsure of how their preparations would translate into a real-world scenario. This is the case of both the respondents who have already been through a RAC audit as well as those who have not.

“We’ve been doing the meetings, we’ve been doing the pre-emptive audits, we’ve purchased a software system to help us track the audit requests. But I don’t know that you can ever say that you’re fully prepared”. Heather Caldwell, Corporate Compliance Officer, St. Mary’s Medical Center

“We don’t know if all these wonderful processes we think we have in place are really going to work the way they mean to when the time comes”. Jan Fowler, Director of Patient Accounting, Saint Vincent Health Center

While respondents who have already been through a RAC audit process have reported differing levels of success with how their preparations have positioned their organization to deal with the audit, all felt that they were now more prepared to handle the actual audit process having been through the demonstration process.

This is partly due to the fact that they were able to evaluate their process and revise those items that didn’t work during the demonstration. One respondent noted that they made quite a few changes as a result of their audit experience, most notably the establishment of a point person to handle communications. Another respondent, who also hired a RAC Coordinator after their demonstration process noted that it was critical for that person to have clinical experience. Another respondent, who hasn’t experienced an audit, but whose corporate organization had been through an audit noted that he felt extremely prepared because the parent corporation had been through and validated their processes.

Other respondents are concerned about the sheer volume of audits that may need to be addressed at any given time, despite the limits on the number of RAC audits that can be conducted in any given timeframe outlined by CMS. Hospitals are subject to 10% of the average monthly Medicare claims, up to a maximum of 200 claims, per 45 day period per NPI^v and other types of organizations, such as hospices or skilled nursing facilities have different maximum limits. Thus, for organizations that handle RAC audits for multiple hospitals or other types of impacted facilities the volume can increase very quickly.

This is also concerning because many respondents anticipate that a large number of their audits will go through the appeals process and the time that it will take to shepherd all of the appeals through the process. One respondent, who had been through the demonstration process, reported that his organization appealed 90 percent of the findings in the initial audit.

Respondents have taken different approaches to handling the appeals process. A number of respondents have reported that their organization has decided that they would rather outsource the appeals process than to try and handle internally. Others have deferred the decision until they have actually gone through the RAC audit process.

“We outsourced our appeals during the demonstration period. We’ve re-evaluated that process and due to lack of resources within our organization, we are going to continue to outsource with a local law

firm. They're doing a great job, so we're going to continue that process". Ginny Kim, Compliance and Privacy Officer, Hoag Memorial Hospital Presbyterian

"We have contracts with two companies that are available to help us in appeals if our volume becomes too large or if we're just having trouble winning some of those appeals that we feel we should be winning". Wendy Trout, Director Corporate Compliance, WellSpan Health

"At this point, we don't anticipate having to outsource, but of course, we haven't been through one". Linda Cole, Vice President of Trauma and Emergency Services, Children's Healthcare of Atlanta

One of the issues that respondents raised with regard to the audit and appeals process was ensuring that the right staff was available to handle pertinent parts of the audit process. While many organizations have hired individuals to oversee the audit letters from the beginning to the end of the process (including audits), one component that was universally identified as critical to the process was ensuring the appropriate clinical staff was available to do records review.

"Our feeling is that it is the physicians who document the records and that is what is going to be evaluated. Physicians can argue the medical issues and clinical issues that our utilization management team can't". Jan Fowler, Director of Patient Accounting, Saint Vincent Health Center

Many respondents believe that hiring a clinical champion to handle this responsibility would be ideal. Some organizations have been able to address this concern and have either ensured that there is a clinical auditor as part of the RAC audit team. Others are relying on nurses and physicians for this review on an "as needed" basis, which can be problematic, pending other daily responsibilities of the clinical staff. Several respondents have not taken this step yet, but are seeking out the right person at their organization. To close this gap, one respondent noted that rather than trying to identify the appropriate internal resource, they were going to rely on their outsourcer to provide this type of expertise.

Another part of the process that was explored in this research was the manner in which documents were accessed and sent to the audit company. Only three of the respondents noted that they relied (or would rely) entirely on paper records to respond to an audit letter or during the appeals process. The remaining respondents reported either that all of their records were electronic or that they relied on a combination of paper records and electronic records to assemble the documentation required for the audit and appeals process. That being said, respondents are choosing to provide their data to the RAC auditor in a different fashion, be it a paper record or on a CD or DVD.

Software Tools

About two-thirds of respondents reported that they use software to help them manage their RAC audit process. These software tools are primarily used to assist in the tracking of RAC requests that come in to the healthcare organization, from the initial request and through the various levels of the appeal process and many of the software tools discussed in this research were able to generate work lists and generate reminders about upcoming

tasks and deadlines. In fact, respondents identified these as critical items that software vendors needed to offer in a viable solution to assist in the RAC audit process.

“Features and functions such as alerts, work lists and RAC timeline reminders are absolutely a necessity when it comes to RAC software. Tracking and timeliness is really one of the keys to be successful in the RAC process”. Pam Chapman, Denials Management/RAC Coordinator, Mercy Medical Center

Respondents also indicated that the reporting component of the software tool is important, as it enables organizations to not only generate reports about the audit process itself, but also to identify patterns of denials by certain physicians, particular codes that were consistently problematic or if there were other areas that warranted additional attention because of frequent audits. It is also beneficial to have one centralized location that everyone can access that has all of the relevant information.

When selecting a system, many respondents noted that they turned to a vendor that was already in place at their organization for a similar function, which fosters integration between systems. For instance, users selected tools that were made by the same vendor that provided their release of information, utilization management or coding tools.

*“We already use this company for other tools and we wanted everything to integrate smoothly. That was definitely a plus”.
Regional Director, Patient Financial Services*

Systems integration was also identified as a key consideration and it appears as though it is more important to respondents that the vendor integrate with the document management system than be from the same vendor that provides the organization’s claims solution. On a scale of one to seven, where one is not at all important and seven is highly important, respondents gave the attribute “integration with document management system” an average score of 5.30. Using the same one to seven scale, respondents had an average score of 3.09 when asked if the RAC vendor should be provided by the same vendor that provides the organizations claims solution.

Several respondents also noted that one of the benefits to their system was the level of flexibility offered by their vendor. Being able to customize the system to their particular specifications has made the systems more user-friendly for users in the environment.

Respondents noted several drawbacks to the systems that are presently available. First, hospitals are subject to audits from other sources outside of the RAC audit process and respondents would like access to a tool that helps them manage the deadlines for all of these processes in a consistent fashion.

Another drawback to the current systems is that they will help to manage the process and let the users know where in the process an audit is, but they can’t handle the process itself.

“Any software you buy is not going to handle the processes as far as looking through your records and those kinds of things; it’s just a tool to keep tabs on what you have out there and what status they are in”. Patient Access/Patient Financial Services

Respondents who did not use software solutions to manage their process offered several reasons for holding back at this time, including costs of the systems or already having a sufficient process in place for which they did not believe they needed to augment at this time. Cost of the system was of particular concern for those respondents that did not have a sense of the scope of audits they were going to get and what the actual financial impact would be on their organization.

Implications

RAC audits are a key issue that healthcare organizations are going to have to address in the future. The financial health of organizations is at stake and they need to aggressively take steps to ensure that they are prepared to handle upcoming audits. The respondents in this study have taken these steps, including establishing formal groups to be responsible for the RAC audit process, investing in software solutions, conducting risk analysis and bringing in outside help to assist in areas where gaps exist. Those respondents that have already been through the demonstration process have taken those experiences and applied them to their processes, making changes and improvements where necessary, and organizations will continue to need to evaluate their processes as the RAC audits unfold.

This research clearly suggests that software solutions have a lot to offer to enhance the RAC audit process. Automating alerts, providing tracking and workflow tools, enabling reports that allow organizations to target areas in which coding can be improved are all areas that will enable an organization to more effectively manage their process. In fact, a number of respondents indicated that these items would be essential for any solution that they would purchase.

However, respondents were also clear that while software will help with the monitoring of the process, human intervention is essential. In its guidelines for the companies conducting the RAC audit, CMS mandated that clinical personnel be employed to evaluate the claims that were being audited. A number of the organizations noted that they had incorporated physicians and nurses in the process of reviewing claims that were audited. Those that hadn't done so at this time indicated this as a weakness in their process that needed to be addressed.

ⁱ Information from CMS press release accessed on February 17, 2010 at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

ⁱⁱ Information was accessed on February 17, 2010 and is available at [http://www.cms.hhs.gov/RAC/Downloads/Recovery%20Audit%20Contractor%20\(RAC\)%20Program%20Slide%20Presentation.pdf](http://www.cms.hhs.gov/RAC/Downloads/Recovery%20Audit%20Contractor%20(RAC)%20Program%20Slide%20Presentation.pdf)

ⁱⁱⁱ Information on defined regions and the contractors assigned to each region can be found in the following CMS press release, which was accessed on February 17, 2010 at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

^{iv} Information from CMS press release accessed on February 17, 2010 at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

^v Information from CMS accessed on February 18, 2010 at [http://www.cms.hhs.gov/RAC/Downloads/Recovery%20Audit%20Contractor%20\(RAC\)%20Program%20Slide%20Presentation.pdf](http://www.cms.hhs.gov/RAC/Downloads/Recovery%20Audit%20Contractor%20(RAC)%20Program%20Slide%20Presentation.pdf)