Topics:Regulatory & Risk Management

Will RACS have to pay for failed recoupments?

Bill pending in Congress would affix financial penalties

November 6, 2012 | By Ron Shinkman

Healthcare recovery auditors (better known as RACs) could face a potential financial penalty for every judgment against a provider that is overturned if a pending bill gets signed into law, according to *HealthLeaders Media*.

The bill, H.R. 6575, sponsored by Rep. Sam Graves (R-Mo.), would allow for the Secretary of the U.S. Department of Health & Human Services to impose a penalty based on a published fee schedule.

Currently, 75 percent of RAC judgments against providers get overturned when they are appealed, mostly at the administrative law level, where a federal judge is making a decision, according to the American Hospital Association RACTrac Survey. The total number of judgments under appeal during the first quarter of 2012 are valued at $380.3 million.

In addition to affixing financial penalties, the bill also would grant much wider leeway to the HHS in determining whether billing errors by hospitals are widespread, rather than granting that power to RACs, *HealthLeaders* reported.

The AHA and hospitals have complained bitterly about the RAC process, and recently filed suit against HHS to recoup denied payments.

To learn more:
- read the *HealthLeaders* article
- check out the bill
- here's the RACTrac survey data

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Hospitals urge OIG to investigate RACs

October 29, 2012 | By Ron Shinkman

The American Hospital Association continues to ratchet up its pressure on recovery auditors (RACs), asking federal regulators to halt all inappropriate denials of payments made by RACs and to streamline all existing integrity programs, reported *AHA News Now*.

The hospital group claimed recovery auditors are "often wrong" but not penalized for being so, according to a letter sent last week to U.S. Department of Health & Human Services Inspector General Daniel R. Levinson by AHA Executive Vice President Rick Pollack. The AHA cited its own survey data, concluding that 75 percent of RAC denials are overturned when appealed.

"The AHA believes that the RAC audit process would improve significantly if auditors were required to improve their accuracy or face financial penalties," Pollack wrote. "In addition, RACs should be prohibited from issuing medical necessity denials, which invalidate the medical judgment of a trained healthcare professional and force hospitals into the costly and complex Medicare appeals process."

Pollack called for the OIG to investigate the issue, *Long-Term Care News* reported.

Moreover, Pollack noted in his letter that overlapping and duplicative efforts among RACs and other CMS contractors overwhelm providers. "For example, RACs, MACs and ZPICs are all charged with reviewing hospital Medicare claims, and hospitals may be required to respond to simultaneous audits of the same claims or to duplicative record requests. These redundant audits drain time, funding and attention that could more effectively be focused on patient care," he wrote.

Earlier this month, the AHA and its member hospitals threw their support behind a bill they say would improve auditing programs by limiting medical record requests, creating financial penalties and requiring medical necessity audits focus on widespread payment errors, *FierceHealthcare* previously reported.

For more information:
- read the *AHA News Now* news brief
- read the *Long-Term Care News* article
- check out the AHA letter (.pdf)

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3 RAC targets to watch for

October 3, 2012 | By Ron Shinkman

Editor's note: The following is an excerpt from FierceHealthFinance's new eBook, Best Practices For Surviving Audits And Denials. *Download the eBook here to read more.*

Auditors go where the money is.

It makes sense--after all, audits are designed to save government and commercial insurers as much money as possible. And payers don't save a whole lot of money issuing line-item denials on saline drips and bandages.

If you know where auditors are most likely to look, you can better fend off their attentions. Consider these three audit hotspots:

1. Medical necessity

Rather than focusing in on the little picture, auditors tend to take a big-picture approach. Auditors will ask not only whether patients required a specific treatment, but also whether they required it in a specific venue. And if the answer is no, the payer could invalidate the entire claim and recoup tens of thousands of dollars.

"Medical necessity is really the hot button," Virginia Sizemore, director of internal audits for nonprofit South Georgia Medical Center in Valdosta, Ga., told *FierceHealthFinance*. For her facility, which is the region's safety-net hospital, providing the right care in the right location is a huge challenge.

"You wind up with a lot of elderly patients with a lot of co-morbidities, and it often makes it [unsafe] for them to be in the outpatient setting," she said. "Then, [if] the facilities do a good job of treating them as an inpatient [and] they get released pretty quickly, the provider is penalized."

According to Sizemore, recovery auditors (better known as RACs) are moving away from diagnosis-related group (DRG) validation--audits focused on what could be potential coding errors--in favor of investigating medical necessity.

Further, medical necessity cases most often focus on complicated medical procedures, such as a pricey medical device. Even relatively simple

"Medical necessity is really the hot

procedures that involve devices could eventually be targets for audits, and in the cases of commercial payers, such claims can be outright denied.

button."

If the claim lies on the fine line between inpatient and outpatient care, it also could be rejected. For instance, a cardiac procedure performed in the catheterization lab can cost tens of thousands of dollars less than one performed in the hospital. And a patient with chest pains hospitalized overnight costs much more in claims than someone who is held for observation care. Again, auditors are more likely to take a closer look at the more complicated and costly scenario.

2. Short stays

Auditors are particularly interested in inpatient stays that last two days or fewer.

Ironically, the shortest stays can be the result of hospitals being overly cautious about admitting a patient.

Baptist Health, a four-hospital system based in Birmingham, Ala., has developed an elaborate checklist to determine whether an inpatient admission should occur. Ironically, the checklist can take so long to complete that the patient actually improves as the process toward admission moves along. In some instances, patients wind up being discharged 20 minutes after they were admitted, according to Jeff Butler, Baptist Health's senior compliance auditor.

"One-day stays are immediately flagged," Butler said. "It makes it a really difficult decision about how you provide the best care for your patient."

3. Cardiac services

At the moment, at least, auditors are paying close attention to cardiac procedures. Trailblazer Health Enterprises, the Dallas-based RAC auditor for Southwestern U.S., lists 19 DRGs on its website that are considered at high risk for audits. Twelve of them fall into the cardiac category.

"You want to be on top of those lists," Jason Pinkall, associate counsel for Dallas -based hospital chain Tenet Healthcare Corp., said last June at the Health Financial Management Association's annual conference in Las Vegas. "You want to educate your hospital about them. It's teaching to the test, as it were."

With price tags of $3,000 or more a piece--plus the cost of implantation--cardiac stents are another audit hotspot.

Be consistent

So you've done your homework and you're up-to-date on the latest audit hotspots. What's next? Coordination and planning is a good start to avoiding audits, Smith said.

Be prepared, too, to make a coherent clinical and legal argument to rationalize care. If you have both and are consistent, auditors will have little in response during the appeals process.

For more tips, check out *FierceHealthFinance's* free eBook, *Best Practices for Surviving Audits and Denials.*

Filed Under Internal Audits, Medical Necessity, South Georgia Medical Center

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Recovery audit appeals can be worth the time

CMS corrected $701.3M in Medicare payments in Q3

October 3, 2012 | By Karen Cheung-Larivee

The Centers for Medicare & Medicaid Services corrected even more Medicare over- and underpayments this quarter, suggesting hospitals should be keeping a close eye on the money.

CMS collected $657.2 million in overpayments and returned $44.1 million in underpayments this past quarter (April to June), compared to $588.4 million and $61.5 million, respectively, in the previous quarter (January to March), according to the CMS corrections sheet.

The top recovery auditor (better known as RACs) issue in the third quarter revolved around medical necessity, particularly for cardiovascular procedures and inpatient stays for minor surgeries and other treatments.

The CMS numbers don't reflect how many of those are overturned on appeal, but as Stacey Levitt, senior administrative director of patient care management at Lenox Hill Hospital in New York City, told *HealthLeaders Media*, "Not everyone is appealing their RAC demands (sadly), but those that do are usually successful."

For those who make the move to appeal, it's worth it. Seventy-five percent of denials from recovery auditors were overturned after a provider filed an appeal, according to the American Hospital Association's RACTrac program's first quarter report.

"I've seen [hospitals] not want to spend the money to fight it, and I don't agree. You sometimes have to send a message."

"I've seen [hospitals] not want to spend the money to fight it, and I don't agree. You sometimes have to send a message," Janice Jacobs, director of coding compliance for IMA Consulting in Chadds Ford, Pa., told *FierceHealthFinance* in an eBook, "Best Practices for Surviving Audits and Denials."

Rebecca Black, vice president of revenue cycle for St. Joseph's Hospital in Atlanta, part of the Georgia-based Emory Healthcare system, also encourages providers to stand their ground. "It's a matter of principle," she told *FierceHealthFinance*.

For more information:
- see the CMS announcement (.pdf)
- read the *HealthLeaders Media* article
- read the RACTrac data (.pdf)
- check out the *FierceHealthFinance* eBook, "Best Practices for Surviving Audits and Denials"

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As RACs get more aggressive, denial costs soar

August 28, 2012 | By Ron Shinkman

Medicare recovery auditors (better known as RAC) activity continues to ramp up aggressively, according to the latest American Hospital Association survey, noted *AHA News Now*.

The RACTrac survey, which includes more than 2,200 hospitals nationwide, reported that the number of RAC-related denials in the second quarter of 2012 was up 24 percent from the first quarter of 2012, while the number of medical records requests was up 22 percent compared to the prior quarter.

The total aggregated dollar value of RAC automated and complex denials has zoomed upward, more than doubling in less than a year. It averaged $224.8 million per the four geographical regions the AHA tracks during the second quarter. That compares to $185.2 million during the first quarter and $110.9 million during the fourth quarter of 2011.

Most of that amount was for complex denials: 97 percent in all. Complex denials also involve far more money, averaging $5,564 during the quarter, versus $548 for automated denials.

Tracking requests for records, coding and documentation and performing self-audits are ways to mitigate RAC activity, reported *PhysBizTech*.

Hospitals are still reporting a high success rate appealing RAC denials or recoupments. According to RACTrac, 40 percent of hospitals are appealing adverse rulings, and 75 percent are winning their appeals.

For more:
- read the *AHA News Now* news brief
- check out the RACTrac survey (.pdf)
- read the *PhysBizTech* article

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Coumajo

If 75% are overturned in appeal, does it lead one to question the validity of the RAC auditors reviews? Is this leading to increased administrative overhead?

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Paul Abramson MD, Paul Abramson MD is a next-generation medical doctor, founder...

Yes

2 months ago in reply to Coumajo Like Reply

Sam

It appears to be the result of a faulty incentive scheme, based on the appearance of activity rather than the reality. If a quality factor were added to the quantity factor--in other words, 30% reversal on appeal would be a gig--then the figures would be more reasonable. It appears that aggressive denial is a response to criticism that RACs were not doing enough. Requiring more bottom line (after appeal) dollars saved/recouped rather than any formal or informal rewards for more denials is necessary.

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Prepayment audits to start Aug. 27

July 31, 2012 | By Karen Cheung-Larivee

The Centers for Medicare & Medicaid Services finally gave the official word on when hospitals should brace themselves for prepayment audits--Aug. 27, the agency quietly announced on its website.

CMS first announced the Recovery Audit Prepayment Review demonstration projection in November 2011 for a Jan. 1 start data and then delayed it to June 1, then again vaguely as the "summer of 2012."

The official launch date of Aug. 27 provides the timeline as to when CMS will target hospitals in states with high volumes of fraud or error-prone providers (Florida, California, Michigan, Texas, New York, Louisiana, Illinois) or many short inpatient stays (Pennsylvania, Ohio, North Carolina, Missouri).

The goal is to cut improper payments before they even happen. Shifting away from the pay-and-chase method, Medicare Recovery Auditors (RAC) will review claims before payment to ensure that providers comply with all Medicare payment rules.

President Obama in 2010 set three goals for cutting improper payments this year: curbing overall payment errors by $50 billion, cutting Medicare error rate in half and recovering $2 billion in improper payments, according to CMS. The prepayment review program is intended to play a big part in preventing fraud, waste and abuse and achieving those goals.

The demonstration project will last for three years.

To learn more:
- read the CMS demonstration website
- see the November announcement

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Hospitals worried about Medicare RAC prepayment audits

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RAC audits targeting DRGs

July 10, 2012 | By Ron Shinkman

Two prominent healthcare attorneys say that a specific group of diagnosis-related group (DRG) codes are drawing the most attention in terms of Medicare recovery audit contractor (RAC) and prepayment audits.

Particular RAC hotspots at the moment concern hospital inpatient treatments for urinary tract disorders, mental healthcare and short inpatient stays (typically two days or less), according to Scott McBride, a partner in the Houston office of Baker & Hostetler law firm.

McBride and Jason Pinkall, an associate counsel for Dallas-based hospital chain Tenet Healthcare Corporation, presented at the Healthcare Financial Management Association's annual conference in Las Vegas late last month.

Pinkall noted that audit attention is being drawn to 19 specific DRGs where hospitals are "feeling some pain." They mostly focus on spinal fusion, hip replacements and unspecific treatment at hospital emergency rooms, usually for nausea and vomiting.

The vast majority of RAC audits result in overpayments being refunded rather than underpayments to providers, according to the Centers for Medicare & Medicaid Services. Nearly three-quarters of RAC overpayment determinations are successfully appealed, according to the American Hospital Association's RACTrac program.

Both McBride and Pinkall urged those entities undergoing audits and ordered to pay back funds to be extremely organized when appealing such judgments, a complex process that can take months, if not years.

To learn more:
- read about the RAC program
- check out the AHA's RACTrac program

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