

(ERRP), which includes agency level strategies to clarify CMS policies and implement new initiatives to reduce improper payments.

In the past, ERRPs have included plans to conduct special pilot studies and specific education-related initiatives. CMS also directs the Medicare claims processing contractors to develop local efforts to lower the error rate by targeting provider education and claim review efforts to those services with the highest improper payments. Some improper payments are best prevented when the Medicare claims processing contractors request and review the medical records associated with the claims prior to payment to ensure that payment is made only for Medicare-covered and medically necessary items and services furnished in the appropriate setting. Other improper payments can best be prevented by CMS or the Medicare claims processing contractors developing new or revised national or local coverage determinations, medical necessity criteria, or billing instructions to assist providers in understanding how to correctly submit claims for medical items and services and under what circumstances the services will be considered medically necessary. Still other improper payments are prevented when CMS and/or Medicare claims processing contractors educate the provider community about existing policies and remind them of the billing mistakes most commonly seen in the claims data.

Due to a growing concern that even with all these efforts, the Medicare Trust Funds may not be adequately protected against improper payments, Congress took action in 2003 by initiating the RAC Program. Congress mandated the Department of Health and Human Services to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare fee for service program. The three-year demonstration program began in March 2005 and initially focused on three high-Medicare utilization states: California, Florida, and New York.

Although providers are acutely familiar with the examination of claims by fiscal intermediaries (FIs) and other governmental contractors, the examination of claims data by RACs has added yet another layer of review. RACs are not intended to replace other review efforts by Fiscal Intermediaries, Medicare Part B and DME Carriers, Program Safeguard Contractors (PSC), Benefit Integrity Support Centers (BISC), Quality Improvement Organizations (QIO) or the Office of Inspector General (OIG). RACs have been given great latitude in determining both who and what will be examined.

RAC-Identified Improper Payment for FY 2007

RACs identified and corrected \$371 million dollars of Medicare improper payments during FY 2007. Over 96 percent of these improper payments were overpayments collected from providers and the remaining 4 percent were underpayments repaid to providers. Notably approximately 85% of most overpayments were collected from inpatient hospitals.

The RAC Program is implemented with a combination of an automated review software program, and medical record review of “claims that were likely to contain improper payments.”

The most commonly identified services for inpatient hospitals associated with overpayments include:

- Excisional debridement
- Inpatient rehabilitation services following joint replacement surgery
- Heart failure and shock
- Surgical procedures in wrong setting
- Respiratory system diagnoses with ventilator support
- Extensive OR procedures unrelated to principal diagnosis

Preparing Your Organization for RAC Implementation

It is clear that the RAC program is here to stay and as such providers should be prepared for the impact of RAC implementation in their states. Critical steps in RAC preparedness include education and internal assessment.

With the nationwide expansion of the RAC initiative mandated by January 2010, all providers must become fully educated on the basic infrastructure for the provision of care as well as the RAC initiative itself so they are better prepared when the RACs begin reviewing their organizations. Both physicians and direct care staff must be fully educated and engaged in the provider's compliance programs, specifically focusing on the coverage and care documentation requirements along with the coding, billing, and payment rules.

The prospective improvement of clinical documentation and improvement in the accuracy of coding practices and claims submission helps to:

- Reduce the amount of RAC recoveries;
- Promote appeals process;
- Promote accurate reimbursement;
- Decrease potential liability for improper submission of claims to federal payers.

It is also critical for the provider to understand the RAC process as well as its obligations and rights during the RAC review. Providers should know that RAC reviews are limited to incorrect payment amounts as well as payments for noncovered, incorrectly coded, or duplicate services.

RACs are required to use data analysis, not random sampling, to identify potentially erroneous payments. Therefore RACs must target claims through data analysis in order to select claims for review. The RACs cannot randomly select claims or only focus on high payment claims.

When necessary, RACs are permitted to conduct onsite provider chart reviews. If medical records are requested by the RAC but not supplied by the provider within 45 days, the RAC may identify the claim as an overpayment by default. RAC requires strict adherence to timeframes in order to observe appeal rights and prevent automatic denials. For example a failure to submit timely first level appeals results in the inability to submit higher level appeals.

Identified overpayments are eligible for repayment over a 12-month period, but the RAC has no power to negotiate settlements. Finally, providers have the right to appeal RAC findings, at which time collection efforts cease until a resolution is determined.

Another useful step in preparation is internal assessment of ongoing compliance programs including policies and procedures. Policies and procedures must be reviewed annual to reflect the current processes in place and the most current Medicare regulations. Evaluation of a provider's compliance program can be achieved through internal audits or reviews. However, many organizations have found that review by an external resource is extremely helpful in identifying issues that require attention. External review not only provides a non-biased, third party perspective on Medicare compliance issues, it is often helpful in evaluating levels of care that may not be a primary expertise of the internal compliance program. For example, inpatient rehabilitation, one program significantly affected by the RAC program as related to medical necessity, may not be an area of expertise of the internal department.

Thus, external review of all provider programs will have significant benefits for the organization. Consulting companies can provide hospitals and physicians with consultative services to ensure that no improper payments occur and to help prevent any RAC investigations.

In order to prevent any repayment to Medicare for overpayments, providers must:

- Ensure that services are appropriately documented to demonstrate that they were medically necessary and meet the Medicare medical necessity criteria for the setting where the service was rendered;
- Ensure services that are correctly coded;
- Assist providers to submit sufficient documentation to support Medicare claims;
- Conduct educational seminars for providers on proper documentation and coding techniques;
- Develop and assist implement corrective action plans based on findings from audit reviews.

Conclusion

As the RAC initiative moves from a three-state demonstration program to a nationwide effort, hospitals must ensure that documentation in all billable services completely and accurately reflects patient status and services provided. Providers should be ready to respond to RAC investigations and should proactively begin assessing all Medicare compliance issues related to medical necessity, documentation, and coding. Those providers committed to working closely with the medical and coding staff to ensure high levels of clinical documentation and appropriate coding, will in turn help guarantee full payment from Medicare.

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