Creating an Efficient—and Effective—RAC Response

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By Karen Wagner

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In the past year, denials and electronic health record requests from the Centers for Medicare & Medicaid Services' (CMS's) recovery audit contractor (RAC) program have increased sharply—and so has the expense of managing RAC activity at hospitals.

"Between the third quarter of 2011 and first quarter of 2012, we saw a huge jump in RAC activity," says Caroline Steinberg, vice president of trends analysis for the American Hospital Association (AHA), which has studied RAC activity at hospitals.

"So many hospitals are reeling from the impact of these audits and are really struggling to come to develop some type of approach," says Larry T. Hegland, medical director for recovery audit services, Ministry Health Care, Wausau, Wis.

In 2008, Ministry Health developed a centralized approach to managing costs related to RAC audits. The plan was implemented in 2010. Since then, about $35 million in payments at Ministry Health has been at risk. Thanks to Ministry Health's innovative approach to managing RAC activity, the health system has recovered about $1 million in payments via appeals processes and about $1 million in underpayments, Hegland says.

How Much Has RAC Spending Increased?

The number of medical records requested from RAC auditors increased from 306,349 records in the third quarter of 2011 to 447,523 records in the first quarter of 2012, according to AHA's May 2012 RACTrac survey, which cites the experiences of 1,854 hospitals that reported RAC activity, out of 2,200 hospitals surveyed. Likewise, the number of automated denials (generated by computer reviews) grew from 30,295 to 50,395 denials at these hospitals, while the number of complex denials (generated by manual review) nearly doubled—from
65,623 to 124,055 denials—during the same time period.

Hospitals also reported spending more resources on managing the RAC process.

Fifty-five percent of all 2,220 respondents (those with and without RAC activity) reported increased administrative costs. Fifty-five percent of hospitals responding reported spending more than $10,000 during the first quarter of 2012, while 34 percent spent more than $25,000 and 7 percent spent more than $100,000, according to the survey.

Hospitals should not overlook the opportunity to control or reduce the costs of managing the RAC process by implementing more efficient practices, especially as audits increase. Recently, CMS doubled the number of charts that can be reviewed every 45 days, from a limit of 450 to about 1,200, says Hegland.

How Ministry Health Did It

Ministry Health, a 15-hospital system that covers north central Wisconsin, created a dedicated RAC operation with a staff of four nurse reviewers, four database coordinators, and an administrative director and medical director who serve the team in a part-time capacity, Hegland says. The team manages the RAC process for all Ministry Health hospitals and physician practices in addition to the health system's home health and hospice services.

process—and this is an incredibly complex process—adding responsibilities for RAC process management to an existing role is not an effective approach," he says. "You really have to have dedicated people with dedicated time overseeing RAC process management. Otherwise, you're leaving money and opportunity on the table."

Staffers who are dedicated to RAC process management will be more effective at RAC management and will be much more likely to avoid repeating processes that do not work, Hegland says. Using dedicated staffers, such as nurses, also minimizes physician involvement in responding to RAC audits and requests. "You want to have a dedicated team that is doing this often enough to become good at it," Hegland says.

At a large system, dedicated staff could include a medical director or physician champion who can handle the clinical aspects of a denial and an administrative director who not only manages the team's operations, but also helps to educate hospital board members, medical staff, and hospital management on the organization's RAC response efforts.

It's also important to ensure that members of the RAC team receive appropriate training regarding the audit and appeals process, along with continuing education that apprises them of revisions to the RAC program. Additionally, senior leaders should be educated on the complexities of the coding process so that dedicating resources to RAC process management will be viewed as a valuable tool for improving the entire coding process—one that leads to fewer audits and denials.

Manage the data flow related to RAC requests and meet deadlines for appeals with a tracking database. "Keeping track of audits is a crucial function that many places struggle with because they don't have a good mechanism of tracking," Hegland says. At Ministry Health, once a denial is entered into the system, the tracking database calculates the deadlines for an appeal and provides reminders, allowing the team to more easily track the status of the appeal.

Use a document management system to convert patient records into electronic files and scan documents for critical information. Every patient record at Ministry Health is converted into an electronic file format, which allows the document to be manipulated and reduces the amount of staff time required to manage documents. Records can be quickly scanned to check if a particular document is missing. Single documents can be easily retrieved and added without having to handle the entire record, Hegland says. Additionally, such a system allows parts of a document to be highlighted, enabling auditors to more easily find information and potentially expediting the appeals process. "We've managed to reduce the amount of manual/clerical effort involved with RAC process management and redirect the team's efforts on more value-added services," he says.

Track the time spent on RAC process management activities. At Ministry Health, the RAC team uses a time-tracker program to manage time spent on each area, from handling audits from physician practices to attending meetings and reporting RAC findings. Ministry Health tracks the time that staff spend on about 40 categories of RAC-related activities. The resulting data enable Hegland to look for opportunities to reallocate the RAC team's time when needed. For example, a time-tracker review revealed that database staffers were spending too much time creating customized dashboards that reported RAC findings to individual hospital leaders. To enable RAC management staff to spend more time on other areas, Ministry Health created a more standardized dashboard that allows staff to report data to leaders more efficiently and in a more uniform way.

Expand the team's efforts to include review of audits from commercial payers. Ministry Health spends nearly $750,000 annually on its auditing operations, including staffing and technology related to these operations. About 40 percent of the staff's time is related to non-RAC audits: The team also handles recovery-style audits from some commercial payers. "In fact, it won't be long before we are managing all of these audits," Hegland says.

A Systematic Process that Reduces Costs

Overall, Hegland says Ministry Health has supplied nearly 488,000 pages of charts for 3,500 audits. With its centralized approach to RAC process management, Ministry Health is well-positioned to withstand the impact of increased RAC activity in the years ahead.

"I think we have produced much better results using a centralized management approach than if we were to have tried to manage RAC-related processes at the hospital level," he says. "We have a systematic process for doing everything related to RAC activity at our health system—and that's how we've achieved such positive results."

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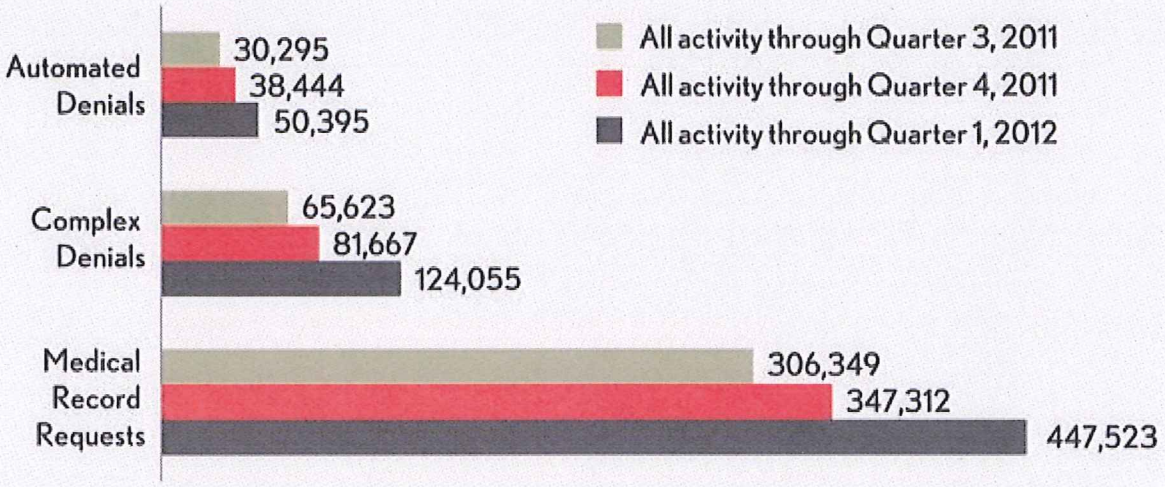
Hospitals Experiencing Dramatic Increase in RAC Denials and Requests*



Source: American Hospital Association RACTrac Survey, May 2012.

* Based on an American Hospital Association analysis of survey data collected from 2,220 hospitals, with 1,854 reporting activity and 366 reporting no activity through March 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals, and inpatient psychiatric hospitals.