



## **Will RAC Change RCM?**

*Hospital leaders are gearing up for the potential of RAC audits to impact the revenue cycle management process.*

**By Steven K. Wagner**

As the federal government's Medicare Recovery Audit Contractor (RAC) program moves forward, one thing is clear: healthcare organizations are responding to the RAC audit program in diverse ways. Just how they respond will affect their revenue cycle management (RCM) effectiveness going forward, with a range of potential implications anticipated.

Industry experts say they can see the challenges and opportunities in the overlap of these concepts quite clearly.

“I would hope [revenue cycle management figures into this],” said Bruce Hallowell, partner and practice director for revenue cycle/healthcare sector with Falls Church, VA-based CSC Corporation, a technology solutions and services company.

Suzanne Whitworth, director in the Healthcare Provider Practice at New York-based Deloitte Consulting LLP, went a step further.

“[Hospital executives] know this is coming, and I certainly think organizations are taking a hard look at their revenue cycle practices, as well as their processes and policies, making sure they have strong internal controls, metrics and ways to monitor how the revenue cycle is functioning,” the Atlanta-base Whitworth said. “You have that middle revenue cycle where the clinical and financial merge, and RAC has found that there are weaknesses in the way that hospitals manage that convergence.”

### **Anticipation fuels action**

In 2003, Congress directed the Department of Health and Human Services to conduct a three-year demonstration program using audit contractors to detect and correct improper Medicare payments. The program was designed to determine whether using RACs would cost-effectively ensure that correct payments are made to providers and suppliers. The program operated between 2005 and 2008 in New York, Massachusetts, Florida, South Carolina and California, returning more than \$900 million in overpayments to the Medicare Trust Fund.

Some liken RAC audits, which are being rolled out nationwide, to IRS audits, which often encourage taxpayers who are fearful of having deductions disallowed to re-examine their receipts in advance of scheduled audits to make sure that all deductions have been claimed—in effect, to minimize their tax burden. Montgomery County Memorial Hospital (MCMH) in Red Oak, IA, is taking a similar approach.

Established in 1920, MCMH is a 25-bed critical access facility situated in America's heartland. Although auditing has not yet begun there, staff are preparing for the eventuality, said Ron Kloewer, the hospital's CIO.

According to Kloewer, a primary challenge facing MCMH is the subjective nature of certain coding and medical necessity parameters. Staff members at the hospital are meeting that challenge by re-examining specific billing categories to make sure that all documentation is in order. In fact, two nurses have been assigned the task of ensuring that admitting and medical necessity criteria are being met and that documentation compliance is in order, in essence ushering the clinical and RCM worlds toward a more seamless interface. Additionally, stand-alone software may eventually be purchased to further automate and streamline these administrative processes—at an expected cost of “tens of thousands of dollars.”

“Our approach has been to look at the entire revenue cycle management (RCM) process to see how the clinical documentation processes match up,” said Kloewer, adding that Montgomery County's net revenue of \$28 million is 65 percent derived from Medicare. “For us, documentation equals coding. The old adage is really true: if it's not documented, it didn't happen.”

### **Success means getting specific**

Being closely examined by MCHC are elements of the RAC audits that have received particular attention elsewhere, including admitting criteria and the administration of IVs and medication. Real costs to the hospital so far, including the two full-time nurses, is less than \$200,000; roughly half of that has been “recouped” in the form of potential revenue denials that were identified and thus mitigated by specifically scrutinizing IV therapy billing.

Meanwhile, the RCM has been bolstered in other areas as the audits approach: the hospital's electronic medical record system has been optimized, billing has been enhanced and collection of late payments has intensified.

“HIM has had to step it up, the IT department has had to step it up, and so have our registrars and clinicians,” Kloewer said. “It's all about finding the holes and getting them plugged.”

### **‘Substantial’ revenue risk**

At Burlington, VT.-based Fletcher Allen Health Care, which is licensed for 562 beds and has a 40 percent Medicare mix, leaders initiated a diagnosis-related group (DRG) validation audit in February with a request for records involving 10 respiratory patient encounters.

“There is direct revenue at risk that could be substantial,” Todd Moore, vice-president/revenue cycle, said of the RAC effort. “This program is not set up to not find anything.”

In anticipation of that, Fletcher Allen budgeted roughly \$3 million to offset any revenue reversals that might occur; by the time the dust clears, the organization expects to have spent an additional several hundred thousand dollars as an indirect result of the audits. That includes funding for a clinical documentation improvement program-including software-to help maximize DRG weight and revenues and a \$20,000 project to identify cases that are under RAC review, flagging those that result in negative remittance. The documentation improvement program, initiated in October, was a direct result of the coming RAC audits, Moore said.

“We pulled the trigger on that one,” he said, adding, “The program has caused us to achieve a much more crisp revenue integrity-we've evolved from billing and after-the-fact compliance to a proactive revenue integrity approach.

“Obviously, we hope that the money we've spent will help prevent a revenue take-back in the future.”

## **Hospital recoups**

If anything can be learned from the experiences of hospital-based organizations to date, it certainly would have to be from those hospitals that participated in the initial federal demonstration project. One of those organizations is Long Beach Memorial Medical Center, a 462-bed acute-care facility in Southern California operated by Memorial Health System, which served as one of the original demonstration facilities. Since then, Long Beach Memorial's investment in an RCM-facilitated appeal of findings-has helped it offset some \$6 million of the \$10.7 million in payments denied under RAC.

“The claims that were denied really added up fast,” said Christopher Finch, chief compliance and audit officer for Memorial Health System (MHS), adding that 30% of the hospital's adult business involves Medicare. “We had to quickly get a process in place to respond to the hundreds of requests we were receiving for medical records-bills and payments-all the way through to appeal. Over time, our people learned what they needed to do.”

According to Finch, many audit findings were legitimate, involving coding errors and medical necessity conflicts. However, the majority were appealed.

While many findings were overturned, the cost to the MHS was significant. Not only did it lose a net \$4.7 million in payments, but the appeal process itself was time-consuming and costly-about \$2,000 per case. The revenue cycle was not unaffected.

And it was impacted again when the hospital began budgeting for future RAC findings.

“We looked at the RAC, looked at what was denied, then we modeled those types of denials and set aside a reserve,” Finch said, adding a caveat. “A lot of the money has come back to the hospital, but we’ve had to pay a lot in administrative costs to get it back,” he stresses.

As a result, expenses are monitored closely, managed care contracts are scrutinized, some costs are shifted and ultimately private payers help to make up the difference.

“We perform routine audits to ensure accurate coding of medical records and use evidence-based screening tools and physician second level reviews to ensure that medical necessity is consistent with the patients' admission status,” Finch said. “These two processes increase our confidence that accounts are correct up front.”

The implications for CIOs are numerous, all those interviewed for this article agree. Among other things, CIOs will need to work closely with CFOs and with their finance teams, as well as with the clinical professionals (such as health information management professionals) who will drill down the several levels needed to prepare for the potential RAC audits to come. Will these initiatives help make hospital organizations successful in this key area? What's clear is that not preparing in this way, all those interviewed for this article agree, is quickly becoming a non-option.