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Eli's Rehab Report

Audits: Get Ready: CMS Is Launching Its Full-Blown RAC Program

What every rehab provider should know about RAC audits in advance.

The Centers for Medicare & Medicaid Services(CMS) is counting on its recovery audit contractor (RAC) program to rake in masses of overpayments -- and your practice or facility's claims could soon be under scrutiny. Inpatient rehab was on RAC's radar from the start in California, Florida, and New York during the demonstration project. Now RACs are looking to go live, and their scrutiny will soon hit rehab providers in all settings across the United States.

Know Who's on the Docket to Scrutinize Your Claims

CMS just awarded contracts to four permanent RACs, the agency announced in an Oct. 6 press release. The contractors who made the cut are as follows:

• Diversified Collection Services, Inc. of Livermore, Calif.; overseeing RAC Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York.

• CGI Technologies and Solutions, Inc. of Fairfax, Va.; over Region B, initially working in Michigan, Indiana, and Minnesota.

• Connolly Consulting Associates, Inc. of Wilton, Conn.; over Region C, initially working in South Carolina, Florida, Colorado, and New Mexico.

• HealthDataInsights, Inc. of Las Vegas; over Region D, initially working in Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona.

Take note: The RACs, selected through a competitive process, get paid on a contingency fee basis on both the overpayments and underpayments they find. The Region A contingency fee is 12.45 percent, Region B is 12.5 percent, Region C is 9 percent, and Region D is 9.49 percent, points out **Rick Gawenda, PT,** director of PM&R for Detroit Receiving Hospital and owner of Gawenda Seminars and Consulting.

The "incentive model" created quite a bit of controversy in the demonstration period, but CMS assured it has selected the new contractors taking into account their technical strength, conflict of interest possibilities, and the competitive contingency fee.

But "how these folks get paid is not relevant," says **Tim Johnson, MBA,** executive director of Castle Rock Medical Group, a Denver-based consulting firm specializing in RAC audits. "What matters is that they're paid to do a job, and they're going to do it."

Timeframe: CMS planned on adding more states to each RAC region in 2009, and Congress set a target date of Jan. 1, 2010, in the Tax Relief and Health Care Act of 2006 for a permanent RAC program to be in place. However, CMS released a notice on Nov. 4 that unsuccessful RAC bidders Viant Inc. and PRG Schultz, USA, Inc. have issued a protest of RAC awards to the General Accountability Office (GAO). Now CMS is required to impose an "automatic stay" on the originally selected contractors until the GAO makes a final determination. That means that the current RACs will have to pause any claims requests or provider education for now, Gawenda says.

The GAO has 100 days to issue its decision, so keep your ear to the ground in early February for more updates. "The four RAC contracts and any work under those contracts are on hold pending the outcomes of the protests," CMS clarified.

Know How RAC Audits Really Work

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If you think that a RAC audit involves a team of people who make a one-stop visit to your clinic, and you pay a bill, think again. "RAC auditors don't need to be physically there," confirms **Richard Gundling, FHFMA, CMA,** VP of thought leadership for the Healthcare Financial Management Association. And it's not a one-shot deal either.

RACs data-mine claims information from their own office, based on industry weaknesses that CMS Quality Improvement Organizations and Comprehensive Error Rate Testing programs have flagged in the past, Johnson explains. "So in theory, you could get requests from a RAC in the mail to review certain claims every single day."

The good news: CMS will be issuing limits on the number of claims RACs can request from each provider, Gawenda points out. CMS announced these limits on Oct. 29, and you can access them at http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage.

You should also know how RACs make their decisions. "It's not a discussion of medical necessity; it's about payment criteria," Johnson tells Eli. The RAC basically checks boxes to see if your documentation meets all the criteria for reimbursement, he says. "And it's not a preponderance of the evidence -- if your claim meets only seven of eight payment criteria, it doesn't matter; you have to meet all eight of them."

Experts Predict Initial Targets

No surprise here, in the inpatient rehab facilities, RACs have been and will continue to be looking at joint cases, says **Fran Fowler, FAAHC,** president and CEO of Fowler Healthcare, an Atlanta-based partner of Health Dimensions Group.

And for outpatient rehab settings, claims with more than 8-12 visits are at risk. "RACs don't differentiate between therapy for neurological problems where a patient could justifiably use 14 visits, versus musculoskeletal cases that use around eight visits," Fowler explains.

"The No. 1 thing we're finding in inpatient rehab is that people simply are not knowledgeable with the requirements in the Medicare Benefits Policy Manual [Chapter 1, section 110] and their LCDs," Johnson says. And "based on our proactive evaluations of hospitals, we believe that documentation of time and of short-term therapy goals will be targets in outpatient rehab."

Looking ahead: RACs may even begin tracking hospital acute care stays and the percentage of patients appropriately admitted to rehab -- and automate the denial process if they note a pattern, Johnson predicts.

Note: For more details on the CMS RAC initiative and what to expect, you can purchase the Eli-sponsored audioconference CD, MACs & RACs: What Every Rehab Provider Should Know, with expert speaker, Rick Gawenda. Go to http://www.audioeducator.com/industry_conference.php?id=1297.

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