



RAC and Long-Term Care Facilities:

Prepare now to avoid future surprises or panic!

Much has been written in the healthcare press about the Recovery Audit Contractor (RAC) program. The purpose of this communication is to provide you with BlumShapiro's perspective on what long-term care providers should know and consider in preparation for a potential RAC audit.

What is the RAC program?

RAC is a program sponsored by the Federal government (through CMS) with the purpose of auditing Medicare claims paid to all providers. CMS has hired outside contractors to perform the audits. A pilot project included five states (Connecticut was not one of them) and resulted in substantial recovery of dollars that had been paid to providers. Based on the results of the pilot project, this program has been rolled out to all states and began in Connecticut on August 1, 2009. Although, as of the date of this article, we are not aware of any nursing facilities being notified of an audit, it is prudent that all facilities take this program seriously and prepare for a RAC audit.

The RAC for Connecticut is Diversified Collection Services. Their website is www.dcsrac.com and their phone number is 1-866-201-0580. It is important to note that the RACs get paid on a contingent fee basis. In other words, they get a percentage of the money recovered. So they are incentivized to find issues and recoup payments.

There are generally two types of RAC audits. One, a simple audit, will look at technical requirements only and identify such things as no prior 3-day stay, duplicate billings, billing for days after the patient has deceased, among others. This will not include a review of the medical record. The other type of review, complex audit, will include the items of a simple audit plus a detailed review of the Medical Record and such things as documentation of units billed, medical necessity, physician certification and compliance with Medicare criteria for services, among others.

The audit will consist of the RAC requesting information from you and then reviewing the information you send in support of a paid claim. The RAC will then notify you of the results, after which there are strict timelines for discussion and appeals. It is important to be aware of the strict timelines, since missing them will not be a good thing. The RAC could simply include the payment as unsupported and claim recoupment. It is also important to understand the audit will be of a sample of Medicare claims, and the results of the sample could be extrapolated to all of the Medicare claims and payments over the period under audit.

What can a nursing facility do to prepare for a RAC audit?

There are a number of things that all facilities should do in preparation for a RAC audit.

- 1) Become familiar with the RAC program. Look at the CMS and DCS websites on a regular basis. They have said that they will post important news and information about the program on their websites.
- 2) Designate one person from your organization as the RAC contact person. This person should be given the responsibility and authority to be the contact person for any communication from CMS or the RAC contractor. You should develop the necessary protocols for handling data requests and communication with the RAC contractor.
- 3) Review your process(es) surrounding medical records documentation and billing documentation. Is all information included in one place, or perhaps in several locations, such as minutes of various clinical committees, lab data, etc? It is important to make sure that all documentation is submitted upon request of a medical record. If anything is missing because it is in another location and was inadvertently omitted, this will cause delays in clearing the audit and potential additional costs of appeal.
- 4) Consider benchmarking your Medicare data against the overall CMS payment data. CMS publishes regional and national data and statistics on Medicare RUG payments. Facilities that fall outside of averages or set norms are more likely to be audited under the RAC program. Also, if your facility falls significantly below the averages or set norms, this could be an indication of not capturing all necessary information to get paid for the services that you are providing (and leaving money on the table). **Attached is the State of Connecticut RUG data for the quarter ended June 30, 2009. This data can be found at <http://www2.cms.hhs.gov>. It is updated on a quarterly basis.**
- 5) Consider performing a pre-audit of medical records. This should include a detailed review of records by a clinical professional, either someone at your facility, or perhaps even an independent coding consultant that is experienced in performing such reviews. This is a good way to really know what the auditor will find when they perform a medical records review. Doing a pre-audit now (rather than waiting for a RAC audit information request) will allow you the necessary time to remediate any findings or weaknesses in your process(es) and will enable you to “put your best foot forward” when the RAC audit comes along.

In conclusion, the best way to prepare for a RAC audit is to be proactive and avoid panic. CMS has provided much information to help providers bill properly for services. They will not be very sympathetic to those that are not following the rules, or cannot prove through documentation in the medical record that they are following the rules.

If you have additional questions about RAC audits, please contact Darrell Pataska, Partner, BlumShapiro at dpataska@blumshapiro.com or 860.561.6835.

RUG III Medicare Frequencies for Connecticut Second Quarter 2009

RUG Group	Number	Percent of Total	RUG Group	Number	Percent of Total
Rehabilitation			Cognitive Impairment		
RUC• Ultra High / ADL 16-18	931	2.9%	IB2• ADL 6-10 w/Nursing Rehabilitation	5	0.0%
RUB• Ultra High / ADL 9-15	2,119	6.5%	IB1• ADL 6-10	193	0.6%
RUA• Ultra High / ADL 4-8	689	2.1%	IA2• ADL 4-5 w/Nursing Rehabilitation	1	0.0%
RVC• Very High / ADL 16-18	887	2.7%	IA1• ADL 4-5	97	0.3%
RVB• Very High / ADL 9-15	2,282	7.0%	Behavior Problems		
RVA• Very High / ADL 4-8	877	2.7%	BB2• ADL 6-10 w/Nursing Rehabilitation	1	0.0%
RHC• High / ADL 13-18	1,262	3.9%	BB1• ADL 6-10	5	0.0%
RHB• High / ADL 8-12	575	1.8%	BA1• ADL 4-5	12	0.0%
RHA• High / ADL 4-7	480	1.5%	Physical Functions		
RMC• Medium / ADL 15-18	653	2.0%	PE2• ADL 16-18 w/Nursing Rehabilitation	12	0.0%
RMB• Medium / ADL 8-14	561	1.7%	PE1• ADL 16-18	299	0.9%
RMA• Medium / ADL 4-7	292	0.9%	PD2• ADL 11-15 w/Nursing Rehabilitation	23	0.1%
RLB• Low / ADL 14-18	21	0.1%	PD1• ADL 11-15	532	1.6%
RLA• Low / ADL 4-13	12	0.0%	PC2• ADL 9-10 w/Nursing Rehabilitation	4	0.0%
Extensive Special Care			PC1• ADL 9-10	53	0.2%
SE3• (3) ADL > 6	456	1.4%	PB1• ADL 6-8	67	0.2%
SE2• (2) ADL > 6	1,053	3.2%	PA1• ADL 4-5	190	0.6%
SE1• (1) ADL > 6	62	0.2%	Rehab Plus Extensive Services		
Special Care			RUX• Ultra High / ADL 16-18	1,460	4.5%
SSC• ADL 17-18	270	0.8%	RUL• Ultra High / ADL 7-15	2,885	8.8%
SSB• ADL 15-16	236	0.7%	RVX• Very High / ADL 16-18	1,574	4.8%
SSA• ADL 4-14	430	1.3%	RVL• Very High / ADL 7-15	2,521	7.7%
Clinically Complex			RMX• Medium / ADL 15-18	3,824	11.7%
CC2• ADL 17-18 w/Depression	102	0.3%	RML• Medium / ADL 7-14	2,421	7.4%
CC1• ADL 17-18	247	0.8%	RLX• Low / ADL 7-18	3	0.0%
CB2• ADL 12-16 w/Depression	251	0.8%			
CB1• ADL 12-16	747	2.3%			
CA2• ADL 4-11 w/Depression	256	0.8%			
CA1• ADL 4-11	670	2.1%			