



An Informational Bulletin Brought To You By Polaris Group

RAC Attack! Are you ready for a RAC Audit?

Recovery Audit Contractors (RAC) are

coming to a state near you, are you ready when they come knocking? The Tax Relief and Healthcare Act of 2006, Section 302 requires a permanent and nationwide RAC program by no later than 2010. Contracted by CMS to perform post payment audits of Medicare providers, RAC audits are looking for over and under payments (also defined as improper payments). Over payments will be recouped, and payment to the RAC auditors is based on a percentage of what they 'find' in overpayments, or 'contingency'. The RAC audits were first a demonstration project in California, Florida and New York, the three largest states for Medicare payments. CMS thought the demonstration so successful, it is being rolled out to all 50 states by 2010.

Between 2005 and 2009 \$852 million of net overpayments were identified. Of the total claims reviewed, over 96% were overpayments!

Types of Audits:

The RAC's will receive a data file from CMS containing National Claims History (NCH). They will also receive updates to this file on a monthly or quarterly basis. From these files they will 'data mine' or search it via queries to find abnormal billing patterns, anomalies, or other such reasons that may warrant a review.

There are two types of post payment audits that a RAC may conduct. One is automated, where they automatically go through claims and 'automatically' find those things that were obviously billed and paid in error. The other is called 'complex' where they actually request medical records to perform an audit to validate whether or not what was paid, is justified or not.

The RAC can request claims as far back as Oct. 1, 2007

They are required to use the same criteria for coverage as the Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC). These include NCD's, LCD's, CMS Manuals, CERT Reports, OIG Workplan, or other items identified in the demonstration period.

How should you prepare?

The best defense is a good offense. Most Healthcare professionals agree a solid Compliance Program is the best way to be prepared. In addition to that, Medicare providers have been experiencing scrutiny for years, either prepayment or post payment audits, through Additional Development Requests (ADR's), Denials, CERT audits, etc.

We have always been held to the requirement that what is billed to Medicare is supported in the clinical record

The best thing to do then is make sure that is in fact the case!

Prior to claim submission it should be reviewed by what is commonly referred to as a 'Triple Check' process. This is where a representative from billing, nursing and rehabilitation come together with the appropriate records and make certain that what is on the claim is supported. This allows you to catch errors in billing before the claim is sent.

Audits on past records should also be performed, focusing on the most recent claims so that a snapshot of current practices can be assessed. Based on the findings of this audit, additional audits may be warranted, or the need for additional training in any of the three main areas: Billing, Nursing, or Therapy. The audit should begin with the clinical record and that information followed through the claim.

It is helpful to bring in outside experts for such an audit so that objectivity is maintained. The time, effort and expense is minimal when you compare that to the information you are supplied with which will allow you to make solid judgments on how prepared you are for a RAC audit.

Burden to Provider:

As in any audit the burden for providing copies of the requested records falls upon the provider being audited. This consumes staff time, supplies, and copy machines.



A process should be developed and in place in anticipation of a request so that all the affected team members know their part in pulling this information together. The number one reason for denials is that the requested information is not provided timely, is not provided at all, or is illegible. Copies must be clear, include the entire page (no cut off corners, etc) and include dates and the beneficiaries name.

The number one reason for denials is that the requested information is not provided.

For the MDS's being reviewed, all the information used in the look back period should be included. Some claims can have as many as 3 different MDS calculated RUG rates, and all the clinical information used in the appropriate look back periods must be included or you risk denial.

Once all the data is collected, it is imperative that an individual in the facility be tasked with the priority of reviewing the record to ensure that everything is in fact included. This is preferably the DON and Administrator. An outside group may also be called upon to do an offsite review of the records and claims prior to submission if time allows. Providers have 45 days to get the information to the RAC once a request has been made.

CMS has issued the Final Revisions to Appendix PP related to Quality of Life F-tags (effective 6/12/09)

Most changes are designed to promote culture change and to de-institutionalize the care practices and environment. Some changes related to environment will have long term impact on how Skilled Nursing Facilities are designed; room set up, fixtures, furniture, and decorating practices. CMS states in the guidance for F252- Safe, Clean, Comfortable and Homelike Environment that "Many facilities cannot immediately make these types of changes, but it should be a goal for all facilities that have not yet made these types of changes to work toward them."

Some Key Changes:

F172: Access and Visitation Right: Reinforcing 24 hour access for non-relative visitors which includes representatives from the State.

F175: Married Couples: Clarifies that this rule not only applies to married couples, but to any two consenting adults.

F241: Dignity - 1) Updated to current expected practices during the dining experience; i.e. Avoidance of Bibs instead of napkins, staff standing over resident during meals and staff conversing with other staff while assisting resident with meals. 2) Encouraging and assisting residents to dress in their own clothes, rather than hospital-type gowns. 3) Changes related to allowing resident to determine hair length and facial hair; 3) Includes reference to limiting signs in rooms which display personal/confidential information. May be put in more private areas such as closet. 4) This does not limit names on doors; and biographical information can be displayed with resident/responsible party consent.

F242 Self Determination: 1) Discusses right to participate in preferred activities even if not offered by facility and includes formal and self-directed activities. 2) Also adding more about choice related to bathing schedules, room mate if both consent, etc.

F246 Accommodation of needs: 1) Stressing making reasonable accommodations and adaptations to resident room, bathroom and common living area. 2) May include making adaptations to bedroom furniture, and fixtures such as sink, drawers, mirror height, lamps, call light etc. The key will be "reasonable" accommodation and is open to interpretation and should be considered in assessments and care planning.

F247 Receive Notice before resident's room or roommate change: Clear documentation of consideration for resident preferences in room changes. Give as much notice and information about the new room mate as possible.

F252 Environment clean and safe and homelike: All examples continue to promote de-institutionalizing the environment. Some examples include: not serving meals on trays, overhead page use, wide spread use of bed and chair alarms, med cart usage, signage on work rooms doors, identical bedding, drapery, etc.

F256 Adequate Lighting: Added examples e.g. lamps to help with reading. Red colored night lights to help



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with night vision to get to the bathroom, dimming switches, contrasting colors floor and baseboards and toilet seats.

F371 Sanitation: All residents have the right to accept food brought to facility by any visitor for any resident.

F461 Resident Rooms: 1) Windows sill height shall not exceed 36 inches. 2) Private closet space or wardrobe in each resident room. 3) If resident is able, can they access and hang clothes etc in closet.

F463 Resident Call Light System: This change allows for de-centralized nurse/care team work areas. With that change, centralized call light systems may not work. For de-centralized systems, this may be a wireless system that the aides carry. The intent is to ensure that residents can contact care givers.

To read the entire article, please visit our website at: <http://www.polaris-group.com/news.asp>

Items Needed for Monthly ‘Triple Check’ prior to Billing Medicare

Triple Check Process:

This review is due monthly before Medicare Part A can be billed. Therapy, Billing, Medical Records, MDS, and Social Services should complete as a team. Any missing data identified in their audit should be recorded and tracked, requested it from the responsible department and obtained before billing can be completed. Billing may also file a copy of audit in resident's financial file. (One therapist can check for all therapies.) To view a partial list of the items to be reviewed, visit our website: <http://www.polaris-group.com/news.asp>

Q & A

“Where No Question Goes Unanswered!”

- Q: Can you add to the physician order recap sheet after the physician has signed and dated it?
 A: No. Once the physician has signed the physician order recap, renewals, changes or updates may not be made to the signed document. New orders should not be added to the recap after the physician has signed the document. AHIMA, Long Term Care Health Information Practice and Documentation Guidelines, Page 98, Section 6.9.11, 9/2001.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following **CEU approved** teleconference trainings

Live Teleconference Trainings

<u>Topic</u>	<u>Date</u>
Tame the Care Plan Monster	6/25
Fall Prevention & Management	6/25
MDS for Administrators	7/9
MDS Fundamentals	7/9
SNF Denials-Cut Letters & Generic Notices	7/16
Mastering ADL Coding	7/16
How Therapy Affects the Survey Process	7/21
Managed Risk/Event Reporting	7/23
Sections I, J, O and W	7/23
QA Audits that work!	7/30
Sections K, P and T	7/30

Please join us in our Teleconferences . For further information regarding these seminars, please contact the Seminar Department at: 800-275-6252 ext. 233 or register at: www.polaris-group.com



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