

Audits may hinge on upcoding

RAC expansion has hospitals wary of how much work it means for them

By Jennifer Lubell

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With auditors beginning the process of conducting more advanced audits in CMS' Recovery Audit Contractor program, some industry experts speculate that RACs will try to sniff out evidence of "upcoding."

The issue is being raised as RACs begin the process of conducting the advanced audits, known as complex reviews.

Connolly Healthcare, the RAC contractor in the CMS region that covers Alabama, Colorado, Florida, Georgia, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee and Texas, announced that it had approved the first issues for complex reviews several weeks ago. Providers in that region, called Region C, could begin seeing medical-record requests.

The broader RAC program, in the stages of final implementation, allows third-party auditors hired by the CMS to keep 9% to 12.5% of payments they identify as improper and collect from providers.

Complex reviews, which require more paperwork and man-hours from hospitals than an automated audit by the RAC, include reviews on patient status, DRG coding, or medical necessity reviews. So far, Connolly has only gotten approval to do complex reviews on DRG validation, according to the CMS.

In light of the recent scrutiny the CMS' new Medicare severity-adjusted DRG coding

system has received over “upcoding” (Dec. 14, p. 8), some sources wonder if this could lead the RACs to do more of these types of complex audits. Anthony Ciuca, a lawyer who is an associate with Mitts Milavec in Philadelphia, said he believes it might, even though the new coding system has only been in place for just a few years.

“It does seem that the RAC is specifically looking to uncover upcoding by hospitals under the MS-DRG system,” Ciuca said. Earlier this year, the 2009 fiscal year workplan for the CMS’ inspector general’s office included an examination of coding trends and patterns under the new system to determine whether specific MS-DRGs were vulnerable to potential upcoding, Ciuca noted.

“I would not be surprised if the RAC is following CMS’ lead and understands that this is a potentially lucrative area to explore,” he said.

Officials for Connolly, based in Wilton, Conn., declined to comment for this story.

Lori Brocato, revenue-cycle-management product manager with HealthPort, a healthcare technology company that consults on the RAC program, isn’t as convinced the MS-DRGs will significantly affect the audit process, but concedes providers in Region C are anxious about the audits nevertheless. “I know nine of our clients have been requested for DRG validation issues. The most we’ve seen so far is in Alabama, where a hospital received 76 requests,” said Brocato, who declined to name the hospital.

Trying to identify the trigger of the RAC audit, “what made the RAC think that they used the incorrect DRG codes” is one of the biggest concerns for hospitals, Brocato said.

“The RAC is questioning the validity of that code, so they have to ask themselves: Do they have everything they need to back the code up? They have to look at issues of upcoding, whether they used a higher reimbursement DRG than they should have,” Brocato said.

Much of the concern is related to the act of responding to the request. In general, it’s very resource-intensive for hospitals to respond to these types of reviews, said Ginny Balla, director of performance services with VHA, a purchasing alliance of hospital organizations based in Irving, Texas.

Hospitals have only 45 days to respond to a RAC notification, said Balla, who leads VHA’s quality documentation improvement team. “Keep in mind these contractors are pulling claims as far back as Oct. 1, 2007. Hospitals may be looking at records that are stored off-site. Parts of these medical records may be paper, parts may be electronic.”

RAC contractors, in conducting these complex reviews, are also getting lots of assistance from certified coders, nurses and physicians, putting additional pressure on hospitals to maintain accuracy in their coding and documentation of claims, Balla said. There’s a lot more opportunities to identify errors than there were in the demonstration project for this program, which didn’t have so many experts looking at medical records, she said.

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“Part of the battle in all of these audits is clinical documentation improvements to make sure every record is accurate for every patient. Hospitals are seeing the need to operationalize themselves internally,” Balla said.

Balla expects that more audits of this type will be issued soon across the country. Now that the CMS has given Connolly the green light to do complex reviews, “I’m sure the other three RACs are soon to follow,” she said.

At this point, all of the RACs have been approved for various DRG validations, said Connie Leonard, director of the CMS’ Division of Recovery Audit Operations, in an e-mail. “Additional issues will be posted to additional RAC Web sites for DRG validation in the near future.”

The American Hospital Association is just starting to hear about the effects of the complex DRG audits, said Rochelle Archuleta, senior associate director of policy with the AHA. Of even greater concern than the DRG audits, however, are the medical-necessity reviews that are expected early next year, she said.

RAC auditors in conducting this other type of complex review, “are going to be second-guessing decisions made by treating physicians at hospitals and patients,” to determine whether medical care given to a patient was necessary or not.

“It’s a complex assessment” on which to base a retroactive decision, Archuleta said.

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