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REDUCING RAC RISK

SAMUEL DONIO,

President and Managing Partner, CBIZ,
discusses how important data mining is
to evaluate a hospital's RAC risk exposure

Future Healthcare In your initial Recovery Audit Contractors (RAC) findings, what has data mining revealed concerning national RAC trends or issues?

Samuel Donio From our data mining and subsequent reviews, we found that many of the target areas the RAC is examining for potential improvement, such as debridements and septicemia, have been well-known integrity-related issues for a number of years. However, hospitals still have significant numbers of patients in these areas that are at risk for recoupment. The average hospital has 19 percent of its cases at risk for an RAC audit. Perhaps factors such as the implementation of the new MS-DRGs have created more difficulties for hospitals ensuring appropriate coding, but from Oct. 1, 2007, when the MS-DRGs were introduced, to the present time, we have not seen any evidence of this.

We have seen inappropriate coding across the board for hospitals. Just as hospitals have made errors that have led to overpayment, they have also failed to code the complexity of their cases appropriately, resulting in underpayment for numerous cases. By our proprietary metrics and benchmarking, we have found that the average hospital has 9 percent of its cases underpaid by Medicare. From our consultative work with hospitals, our data mining experience and our past and current compliance initiatives, we believe that there would be significant opportunities for the RAC in most hospitals. In actuality, once we have run a hospital's real data through our RAC criteria, the results have reinforced the need for hospitals to make significant coding improvements. The RAC is real, and from where we stand, too many hospitals are not prepared to deal with the consequences that follow.

FH How can hospitals mitigate their RAC risk exposure and prioritize their RAC preparedness using data mining?

SD One of the major RAC target areas is outpatient surgical procedures performed as inpatient procedures. For instance, cardiac device procedures like pacemakers can be done as an outpatient or inpatient procedure. However, there has been a sufficient medical necessity determined by Medicare using Medicare InterQual guidelines for the procedure to warrant an inpatient stay, which is more costly and has a significantly higher reimbursement. If the inpatient does not have the proper physician documentation and accompanying procedures, Medicare can reduce, or even in some cases withhold, payment. The RACs are looking at these inpatient cases to determine if the patient stay was necessary.

We are working with a major teaching hospital that had 1,299 cases over a 12-month period that would be subject to this RAC target area. In order to examine these cases, this hospital would have to spend significant sums of money and resources to pull each chart and examine all 1,299 cases individually — a cost of \$100,000 minimum. A random audit may look at 100 or 200 of these cases; however, our results have shown that both of these approaches are a waste of time and resources. Through our data mining, we found out that this hospital only had 118 cases at risk out of the 1,299, or 9 percent. Thus, it would be unnecessary and costly for a hospital to commit resources to examine all 1,299 cases. The random-audit approach to this problem would be even more dangerous. Is there any certainty that the small sample would even correctly estimate the proper number of cases at risk? If only 9 percent of the cases are at risk and a hospital is examining only 10 to 15 percent of the cases, the

likelihood of proper mitigation in this target area is highly unlikely using a random-sample methodology. With data mining, a hospital can obtain an accurate "snapshot" of their risk exposure without committing significant internal and external resources. This hospital would have committed hundreds of man hours or a comparable consultative price in trying to assess their risk.

A good data mining system will also shed light on the types of cases that continually subject the hospital to risk. Those cases, especially if they are "high-dollar" cases, should be the hospital's priority. We worked with one hospital that had 696 cases that would be subject to this list. However, only six percent of those cases were subject to any risk. The hospital really wanted to devote more of their resources to inpatient coding — in this instance, where 21 percent of their cases were at risk. By using data mining, the hospital was able to prioritize its RAC efforts. Instead of examining all 696 cases in a RAC-targeted area that was not a comparatively high-risk area, the hospital devoted its resources to a more pressing RAC target area. In terms of mitigation, the hospital now examined those inpatient coding cases that put the hospital most at risk and made the necessary changes, such as coder education, hardening the patient record, if appropriate, through physician queries and setting up hospital-wide best practices which lead to appropriate coding. Without data mining, a hospital's mitigation and overall RAC preparedness would be arbitrary and incomplete.

FH If providers do not use a data-mining approach to evaluate their RAC exposure, what problems can occur?

SD If a provider does not use data mining to evaluate its RAC exposure, it will not be adequately



“WITHOUT DATA MINING, A HOSPITAL’S MITIGATION AND OVERALL RAC PREPAREDNESS WOULD BE ARBITRARY AND INCOMPLETE.”

prepared for the RAC. From a financial-planning perspective, any RAC assessment without data mining is incomplete, and therefore not sufficiently serving the needs of the hospital. From a medical-records perspective, there cannot be an adequate understanding of the risks, or in some cases, the lack of risk the hospitals face from inappropriate coding. For case management, the knowledge that the hospital's InterQual and Medicare guidelines are being consistently followed cannot be ascertained without data mining. Finally, from a compliance standpoint, the hospital cannot determine if they face substantive and repeated problems with national fiscal intermediary guidelines without using data mining.

Essentially, hospitals will not know vulnerabilities for the RAC, not to mention other compliance or integrity initiatives, without data mining. For example, a hospital we are working with had no prior knowledge that approximately 70 percent of its short-stay inpatient cases — cases with an inpatient stay of less than three days — were at risk for RAC recoupment. Another hospital that we are working with was convinced they had a problem RAC-targeted area that involved third-day transfers to a skilled nursing facility. After examining all of their cases through data mining, we found that only two percent of their 933 total cases were at risk. This is not to say that those cases that make up the two percent are unimportant; however, the hospital can now place the proper emphasis — resources, time and money — on their real RAC exposure. Through data mining, hospital decision-makers can effectively prioritize their RAC response.

FH How specifically does data mining and the R4 approach drive a comprehensive RAC preparedness approach?

SD At CBIZ KA Consulting Services, the tools we use range from our data-mining product to RAC R4 reports to drive a comprehensive solution for RAC preparedness. We work with providers on the high-risk RAC target areas and cases that are likely to be audited by the RAC. This approach presents an accurate reflection of a hospital's RAC exposure. The R4, which stands for RAC Risk and Reward Reporting, helps to determine our consultative approach. For instance, if a hospital's R4 results indicate that 70 percent of their at-risk cases are inpatient coding, we will provide a team of experts to appropriately meet that need. Our teams of experts include HIMs professionals, nurses, and utilization review and case management specialists. Similarly, we prepare a mock RAC audit for clients that focus on the particular needs of hospitals. Using the results of our R4 reports and virtual assessment, we determine which cases a hospital must collect for us to review. Operationally, we use the workflow assessment to identify areas and procedures in hospitals that need to be improved in response to the RAC request. We work with hospitals to pinpoint best practices, so that they will have a uniform and systematic response to RAC requests.

For multi-hospital systems and large hospitals, we use the R-Flow, which is a RAC-tracking software product that coordinates RAC record activity throughout the hospital or system. The R-Flow uses the results of our data mining to adequately track the records in question, and it also

provides a mechanism for us to analyze operational and clinical problem areas throughout a larger hospital system. Using our HIPPA compliance system, the client can easily upload and store records so that they are prepared to find and submit records for RAC requests. Finally, our data mining helps us to identify the proper education tools and materials needed for hospitals to prepare for RAC mitigation. Hospitals can use our on-site educational programs that focus on coding, compliance and physician documentation, or we can design an online education program that gives hospitals the opportunity to administer education materials to its employees from multi-hospital systems or remote locations.

FH When considering a data-mining approach to use for RAC preparedness, what should hospitals look for regarding a comprehensive solution?

SD The solution must provide information about specific cases and their levels of risk exposure. It should also help you identify cases that may be subject to RAC recoupment, as well as cases that may identify areas of underpayment. They should also be able to use the results to acquire an overall assessment of RAC exposure. It should help you identify areas for additional education. A great tool will provide you not only with a means of reducing your risk, but it will also identify areas where better documentation will lead to improved reimbursement. An examination of potential billing opportunities is also a key element. In conclusion, it should give you a head start by highlighting areas for appeal preparation. **FH**



SAMUEL DONIO, President of CBIZ KA Consulting Services, LLC, has been an innovator in the healthcare industry for 25 years. An authority on sound and compliant healthcare financial management, Mr. Donio has developed numerous products and services to meet the needs of healthcare providers. Mr. Donio was one of the first consultants to work with the Medicare DRG system, and has developed software platforms that help hospitals improve their clinical coding and financial performance through better documentation and compliance. Mr. Donio received an M.B.A. from Monmouth University and a B.S. from St. Joseph's University. He has been an adjunct professor at Rutgers University-Camden and is an Advanced Member of the Healthcare Financial Management Association.

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