Recovery Audit Contractor Program:
The Experience of Intermountain Healthcare

The United States Senate Committee on Finance
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Written Testimony – Suzie Draper, Vice President of Business Ethics & Compliance, Intermountain Healthcare

Intermountain Healthcare appreciates the opportunity to describe its experience with the Recovery Audit Contractor ("RAC") program. My name is Suzie Draper, and I am the Vice President of Business Ethics & Compliance at Intermountain Healthcare in Salt Lake City, Utah. Intermountain is a not-for-profit 501(c)(3) integrated healthcare system that operates 22 hospitals in Utah and Idaho; more than 185 clinics; and an insurance plan, SelectHealth, which covers more than 600,000 lives in Utah and Idaho. Intermountain's Medical Group employs approximately 1,200 physicians, and about 5,000 other physicians affiliate with Intermountain.

Intermountain has become well-known nationally and internationally for identifying best clinical practices and applying them consistently. Dr. John E. Wennberg of the Dartmouth Institute for Health Policy and Clinical Practice said "Intermountain is the best model in the country of how you can actually change health care for the better." Dartmouth estimated that if healthcare were practiced nationally in the way it is provided at Intermountain, "the nation could reduce healthcare spending for acute and chronic illnesses by more than 40%."

Intermountain's focus is on providing high-value healthcare. To that end, we:

- Have developed physician-led clinical programs so that medicine at Intermountain is practiced by collaborative teams and is based on the best available data.
- Establish specific clinical improvement goals, with accountability for accomplishing these goals reaching all the way to Intermountain's Board of Trustees.
- Have developed information technology that allows us to track, compare, and improve outcomes—and eliminate inappropriate variation.
- View variation as an opportunity to improve, whether we find it in our clinical processes, our business processes, or our supply chain.

Introduction

The RAC Program has been the largest Medicare claims auditing initiative in which Intermountain has participated. The objective of this written testimony is to provide the Committee with an overview of Intermountain's experience with the RAC program.

Benefits of the RAC Program to Intermountain

When the RAC program became permanent, Intermountain began by working with key operational departments to develop an infrastructure to respond to the new regulatory demands. After this

assessment phase, an enforcement response strategy was implemented that has allowed Intermountain to interface successfully with the RAC Program–retaining appropriate payments and returning those that were received in error. A crucial piece of this infrastructure was the development of more efficient systems to track and report claims data. Because of careful planning and preparation, Intermountain has developed mechanisms to benchmark against other healthcare systems and to provide critical data to our internal stakeholders involved in process improvement.

A few of our successes related to the RAC Program include:

(1) Processing more than 16,000 RAC requests for individual patient medical records without a single denial for untimely responses.

(2) For audits requiring a chart review, 60% have been approved with no errors found as compared to 52% for our region.

(3) More than 81% of the denials have been appealed as compared to 48% for the region.

(4) More than 90% of those appeals resulted in the denials being overturned in Intermountain's favor, compared to 62% for the region.

(*Region data used Q4 2012 AHA's RACTrac Report*).

Largely because of the high level of commitment by senior management and staff, as well as the ability to internally share and analyze the data, Intermountain has been able to refine and adapt the enforcement response strategy for continued success.

Another benefit gained from the RAC program comes from the specific manner in which the contractors identify the issues they are going to audit. While some government audit entities will simply state they will be reviewing claims for "excessive units," for example, the RACs will provide more specific information on what type of units they will examine. The RACs have posted more than 600 specific issues they are auditing, which allows us to complete our own internal audits to proactively review claims, correct them, and develop internal processes as needed to avoid future overpayments.

Lastly, because the RACs were given the responsibility to review underpayments and overpayments, Intermountain has received more than $1.8 million in additional Medicare payments as a result of the RAC-identified underpayments.

RAC Audit Activity for Intermountain Healthcare

Figure 1.a shows the number of claims and the Medicare payment amounts reviewed by our region's RAC. Of the 25,473 claims reviewed, more than 16,000 required Intermountain to send the RAC complete patient medical records.

Figure 1.a

Claims Requested/Reviewed	Total Claims	Original Medicare Payment Reviewed
Claims Resolved	17,437	$78,978,764
Unresolved Claims (Intermountain determining to appeal or claims are in the appeal process)	6,245	$24,453,305
Pending Completion of RAC Review	1,791	$16,214,260
Total	**25,473**	**$119,646,329**

Figure 1.b provides detail on the 17,437 claims that have been completely resolved. As indicated below, more than half of all claims resolved were found with no error. The RAC did find almost $1.9 million in underpayments that have been returned to Intermountain and slightly more than $1.9 million in overpayments have been returned from Intermountain to the Medicare fund. Accordingly, of the approximately $120 million dollars in claims examined, Intermountain has realized a net loss of just over $16,000. Put another way, the audit of $120 million dollars in Medicare payments made to Intermountain has thus far resulted in about $16,000 being returned to the Medicare program.

Figure 1.b

Claims Resolved Detail	Total Claims	Actual Medicare Payment Gain or Loss
No Error Found (No Loss or Gain)	8,805	$0
Underpayment Amount (Gain)	678	$1,887,176
Overpayment Amount (Loss)	7,954	-$1,903,620
Total	**17,437**	**-$16,444**

Intermountain's Current RAC Burdens

The RAC Program has placed many burdens on Intermountain, from the release of medical records process through the appeals process. Overall, the information below shows that – at least at Intermountain - the RAC program is not helping reduce healthcare costs and that the program diverts resources that might otherwise be applied to quality improvement and patient care.

Intermountain has increased staffing in order to be able to manage and comply with the RAC program. We estimate that 22 additional full-time employees have been added, with the majority going to the Appeals Unit, the release of information groups, patient account staff, legal representatives, physician advisors, case managers, and a centralized RAC manager.

The processing of more than 16,000 medical records for transmission to the RAC has produced a heavy operational burden on our Health Information Management team. It is not unusual for the same record to be produced multiple times due to RAC operational issues. Software updates and computer programming to manage the release of records process is ongoing. Daily operations are impacted when the RAC requests multiple records at once and the staff must prioritize work to log requests, locate, copy, and package records. We have found it necessary to continuously educate our Health Information Management staff to keep them current on the regulatory changes to RAC processes. The staff is also

involved in the appeal preparation, since they must review records, validate coding decisions, and go to hearings to present justifications for particular coding assignments.

Multiple government auditors are requesting the same records. There have been cases where other government auditors and the RAC are requesting the same records for audit review. We have also experienced the RAC requesting the same records for review for the same issue more than once, even though this is not allowed according to the RAC Statement of Work.

- *Case Study:* An account was requested by the RAC in 2012 and an overpayment was alleged, but Intermountain personnel determined the denial was not correct and began the appeals process. The denial was overturned in our favor during the first level of appeal; however, 10 months later, the RAC requested the medical record again to perform an audit for the same reason as the first audit. According to the RAC Statement of Work, this is not permissible.

Intermountain has been burdened administratively in various ways. Claims found through the Automated process (data mining) are focused on appropriate coding and charging of accounts. When reviewing these accounts we must assess the account, use resources to pull the medical record chart, assess that the appropriate codes have been used, ensure that charging is appropriate, and then rebill the account (if needed). It takes on average, one hour to analyze each of these accounts.

Claims found through the Complex process (review of entire patient medical record) require the RAC to audit if the level of care was appropriate (inpatient versus outpatient) and to validate that the Diagnosis Related Group code was appropriately assigned. Resources to appeal these accounts include the pulling of the medical records, the assessment of the care by a clinician (physician and nursing), the re-assessment of the coding and the time invested in appealing the account. It takes on average, five hours to analyze, assess, and appeal each of these accounts.

The RAC Statement of Work (SOW) is to identify over/under payments and to identify fraud and abuse (SOW Program Purpose). In practice, the scope of the RAC Program seems to have expanded. We now have to justify that the care given to the patient was appropriate, that the patient stayed the right amount of time, and that the physician status order which was obtained upon admission was checked appropriately, all without being given criteria from CMS as to what those specifications should be. One example is the level of care deemed appropriate for a cardiac stent placement.

- *Case Study:* For cardiac stent placement, patients are given Integrilin as an anti-platelet to eliminate blockage of the stent. At the first level of appeal, regardless of the time that the patient is receiving that medication, these claims are denied inpatient status, and we are told that billing for inpatient care is fraud/abuse. At our second level of appeal, the contractor has criteria that the patient should be an inpatient if the patient is on the medication more than six hours (a change from last year where they stated the patient had to be on the medication for more than 18 hours). At the third level of appeal, the administrative law judge (ALJ) may have differing opinions on Integrilin, dependent on the ALJ. We have not yet had a fourth level of

appeal with these cases and do not know what the Medicare Administrative Contractor's view will be, but we have seen that the criteria used by different contractors are inconsistent.

Intermountain has had many hearings and received denials based on the *outcome* of the patient's treatment, not on the original intent of the physician at the time of the admission. For example, if a Patient Status Order does not match the outcome, we experience a denial. In other words, if a patient's condition indicates to a physician that an inpatient admission is called for, but the patient subsequently improves more quickly than the original expected length of stay, the RAC will in hindsight determine that the physician's original assessment was incorrect. Providers who have worked diligently to improve patient outcomes so that patients improve rapidly are essentially penalized for their efforts to improve patient care and shorten patient length of stay. In addition, while the physician's decisions determine the patient care, the hospital or clinic is held financially liable for the patient's status. Thus, on the one hand, the administrative burden is detracting from the focus on patient care, while on the other hand, strict adherence to administrative details results in the denial of coverage for care provided.

The initial RAC program and timelines have not been adhered to by the private contractors. While a provider can have its payments recalled because it did not submit medical records to contractors on time, the private contractors have not in turn adhered to their timelines. We have had contractors state, 'We are short-staffed, so you might as well bypass our level and go straight to the ALJ.' When we do that and go to the ALJ, the ALJ sometimes remands it back to the second level because they do not have the clinical expertise to decide on the appropriate level of care.

The RAC is not providing the Informational Letters for Automated (data mining) audits that they perform. These letters provide the necessary information that tells us the specific issues related to the denials. Without this letter, it has proved difficult to determine to which of the more than 600 issues the account is related. Additionally, the letters we receive from private contractors do not give us the reasons for denials.

While the RAC SOW states that the RACs should not be a burden to providers (42 CFR § 405.980), excessive resources have been used to re-code accounts, reassess levels of care, re-bill accounts, pull medical records, etc. The account is then reviewed by a third party who assesses the care from a subjective viewpoint. The SOW also stated that RACs would only recall the "difference" between the inpatient and outpatient payments, but Intermountain has had to refund the entire payment amount until we appeal the account.

Under 42 CFR § 405.980, the RACs are required to comply with reopening regulations, which state that before "a RAC makes a decision to reopen a claim, the RAC must have good cause." We believe that the data mining has not identified errors on our part, with our "favorable, overturned rate" of over 90%. In our first level of appeal, we get 5% of our denials overturned. On the second level, we get 10-15% of our denials overturned and on the third level, nearly 85% of denials are overturned. The ALJs are finding that

appropriate care was given to the patient and, without specific criteria to determine outpatient versus inpatient at the time of admission (or an outcome), are ruling in our favor.

At the third level of appeal with the ALJ, the wait time for an ALJ hearing is two years out, so many of the accounts are not resolved for more than three years. To alleviate the overburdened process, CMS established the Part B interim billing process, which took the authority away from the ALJs and promised to return "some type of payment" to the providers. Issues with this ruling are in direct conflict with the RAC SOW because of the burden it places on the providers to rebill (indeed, the rebilling is so complicated that CMS is having difficulty programming their system to accept these claims). To rebill an account under the interim ruling will require Intermountain to employ an additional six FTEs for coding, billing and clinical resources, spending more than five hours to assess each account. It also places an additional financial burden on the beneficiaries for their copayments on claims that are over three years old. This creates dissatisfaction between the patients and the providers.

There appear to be more RAC audit errors than provider errors. Where other providers may be backing out of the appeal process due to financial or other constraints, Intermountain has taken the approach of appealing all denied cases where we deem the original payment we received was justified. We currently appeal 81% of all claims the RAC finds in error. Of the 81% we have appealed, we have more than a 90% success rate of the denials being overturned in our favor. Despite this success rate, the RAC has not changed the process or criteria for denials. There is no direct communication between the RAC and providers to improve the process or reduce the number of unnecessary denials.

Physician decisions are being overturned by auditors who perform the medical necessity reviews for the RAC. Intermountain uses a process in which external and internal physician advisors review cases for appropriate inpatient admissions, and we are still receiving denials on these cases.

RAC denials are not always appropriate due to the following reasons:

- Recent denials by RAC have raised concerns about patient safety and care.
    - *Case Study:* Recently we have seen frequent denials of cases such as those for pulmonary embolisms (a condition related to blood clots in lungs). Pulmonary embolism is the third most common cause of death in hospitalized patients, with at least 650,000 cases occurring annually. Autopsy studies have shown that approximately 60% of patients who have died in the hospital had pulmonary embolism.[1] Although low-risk pulmonary embolism can be treated safely on an outpatient basis, the majority of Medicare patients are high risks, and most medical literature recommends hospital admission for these patients. Failure to admit and treat the patient with this condition in hospitals puts the beneficiary at high risk of complications and possible death. It also exposes the provider to the risk of medical malpractice liability; in the event of a negative outcome, plaintiffs' attorneys will question any decision that seems to go against the weight of medical opinion.

[1] Medscape: Pulmonary Embolism Author: Daniel R Ouellette, MD, FCCP; Chief Editor: Zab Mosenifar, MD.

- The RAC does not recognize Intermountain's utilization review system as a valid process. Intermountain, like most providers, usually follow nationally established screening tools (such as InterQual or Miliman), but the RAC has denied many of those cases which met screening criteria for inpatient and outpatient status.

- The RAC does not consider or apply established clinical guidelines published by nationally known associations or medical journals (e.g., the American Heart Rhythm Society guidelines for cardiac procedures or chest guidelines related to pulmonary embolism).

- Currently, most RACs do not have not enough resources to review all denied cases by a physician as required by CMS. CMS requires all downgrades of medical necessity cases to be reviewed by a physician. "The case is referred to a physician reviewer when the non-physician reviewer cannot approve the hospitalization as necessary and/or another level of care would have been appropriate without posing a threat to the safety or health of the patient."[2]

The RAC cannot determine which accounts we have corrected or adjusted in the past. As Intermountain conducts internal audits to identify problematic claims, identified coding and billing errors are corrected resulting in an adjusted claim. The RAC data-mines these adjusted claims and concludes that we have billed and received payment for two discharges or for excessive units, which, if they could see the corrected or adjusted payments, they would not have denied. The RAC's solution for Intermountain was to submit an appeal on each claim.

- *Case Study:* Our Medical Group has identified more than 1,250 claims that fall into the aforementioned category. Intermountain would need to appeal each of the 1,250 claims (and any similar future claims) which would create a financial burden on our business as well as to our Medicare Administrative Contractor who would be processing a large number of redetermination requests that could easily be avoided. The Intermountain Medical Group continues to receive 20 to 30 newly identified claims that are a part of this issue each week. We have tried to work through this issue with the RAC, but to no avail.

Conclusion

Preparing to operate in the RAC program environment has produced a few benefits for Intermountain in that we have improved some specific processes in order to accommodate the program. However, the burden the RAC program has placed on Intermountain–and by extension, its patients and payers—is substantial as detailed in the foregoing testimony. At least in our experience, the RAC program is not producing significant payment recoupment by the Medicare program and is, instead, adding to the cost of healthcare.

Within the RAC Statement of Work it is clearly stated that the RAC Program should not be a burden. We've added 22 FTEs, resolved over 17,000 claims, we are currently appealing over 6,000 claims, and

[2] Quality Improvement Organization Manual Chapter 4 - Case Review 4110 - Admission/Discharge Review.

the RAC is currently reviewing over 1,700 claims. Intermountain has had a total Medicare payment review of approximately $120 million; after all this, Medicare has recovered only a net of about $16,000 (underpayment amount gained = $1,887,176; overpayment amount lost= $1,903,620).

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