

# 2013 RECOVERY AUDITOR BENCHMARKING REPORT



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## 2013 Recovery Auditor Benchmarking Report executive summary



Thank you for reading our *2013 Recovery Auditor Benchmarking Report*. We've been on quite a ride since the start of the Recovery Auditor (RA) demonstration project, and in 2012, RAs continued to expand. This report examines how providers have adjusted their approach in the past year, and it looks forward to some new initiatives and proposals that could alter the state of RAs as a whole.

In this year's survey, we had 325 respondents, representing both small and large hospitals, from all four RA regions. These respondents represented a number of different departments, including compliance, HIM, PFS, case management, and clinical documentation improvement. While some of the information provided in this survey may not come as much of a surprise, there are some items of note that we will go through. The main theme of this year's survey is the growing state of the RAs, and the fact that they only seem to be gaining speed.

This theme becomes apparent almost immediately as we look at the percentage of providers that have had recoupments from automated reviews—it has risen by 14% this year. In addition, the amount of providers that have seen record requests for complex or semi-automated reviews has gone from 82% to 91%. This may not be shocking, as CMS continues to approve more issues and the scope of the RAs continues to expand, but it highlights the fact that the audits are ever-changing and will force providers to stay on their toes.

I won't go into question-by-question detail here in this summary, but I would like to highlight some of the recent developments in the RA program that providers need to keep an eye on. First is the arrival of the prepayment RA reviews. As of right now, only two issues have been approved—MS-DRGs 312 and 069—with short inpatient hospital stays looming, and only 11 states are in the prepayment demonstration, but that does not mean that providers are unfamiliar with the prepayment review process. According to our survey, 74% of respondents have seen a prepayment review either from their MAC (52%), their RA (6%), or both (16%).

When it comes to provider preparation for these prepayment reviews, our respondents were split. A total of 52% said that they are not specifically changing any internal processes, but 33% did say that they've heightened awareness in departments that are impacted by RAs. However, almost half of the respondents have felt the need to revise internal processes to meet auditor scrutiny, which appears to be increasing from year to year. As the RA program expands, providers need to be flexible to adjust to current issues and anticipate upcoming reviews.

Another current RA-related demonstration project is the Part A to Part B rebilling demonstration. Twenty-eight of our respondents indicated that their facility is one of the 380 hospitals participating in this demo, and the majority of them (62%) have been able to rebill and get reimbursed. Only 14% have not rebilled anything yet, but were planning on doing so in the future. This demonstration project will last three years, and although it could assist facilities in recouping some of their costs for inpatient stays that were deemed not medically necessary, it is certainly not an answer to resolving the daily operational issues facilities face.

The third recent development is the complaint filed by the American Hospital Association (AHA) against RAs. As you all probably know, the AHA, along with several other hospitals, issued a lawsuit against the RAs for unfair Medicare practices. Based on this bold move, I was curious what respondents thought about the initial action. Sixty percent think that *something* will happen as a result of the complaint, but 43% of those think that it will only involve very minor changes. On the other side, 17% think that nothing will happen, while 25% are just happy to see the RAs being called out on their current practices. This will be an interesting topic to follow and may set a precedent for other audit processes. Although respondents appear to be pessimistic regarding the potential outcome of the lawsuit, the fact that RAs are being challenged should give providers hope for changes going forward.

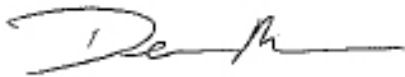
At this point last year, none of these aforementioned items would have been on the table for discussion, but as the RA program expands, so does the knowledge and preparation of providers.

According to the respondents, critical access hospitals (CAH) seem to be reporting little activity across most RA regions—but providers should keep in mind that the unique environments of CAHs tend to set up higher billing risks in certain areas. Many of the same PPS documentation, coding, and billing guidance also applies to CAHs; the difference is in the payment and not in the application of the rule. CAHs should regularly review their RA's issues list, audit for any areas of concern, and make operational adjustments as needed. For CAHs, it is not about if the RA program takes off, but when.

As a whole, I think this survey shows not only how far RAs have come, but how far providers have come as well. Comparing the numbers to previous years' survey is telling: increased use of dedicated RA coordinators, increased involvement of physicians on RA teams, and a more targeted, focused use of the UR committee. These are only a few examples of how providers are growing along with the RAs and will continue to do so in the future.

Thank you for reading, and we hope that you find this helpful!

Sincerely,



Debbie Mackaman, RHIA, CHCO  
Regulatory Specialist  
HCPro, Inc.

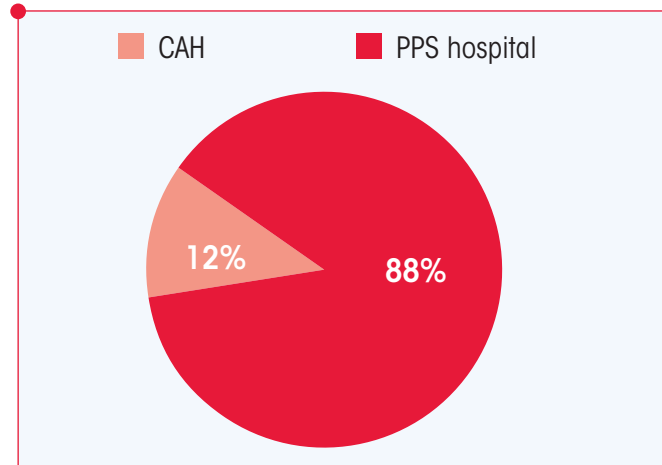
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## Type of hospital

In this year's survey, we had 325 healthcare professionals check in with us. Of those respondents, the overwhelming majority was employed by a prospective payment system hospital (88%), while 12% came from a critical access hospital (CAH). This year, we wanted to know how many of our respondents were from the CAH setting to get a better understanding of any activity they may be experiencing. CMS has been clear that CAHs would be open to Recovery Auditor (RA) reviews; however, it appears review activity in these hospitals may have gotten off to a slow start. <sup>n</sup>

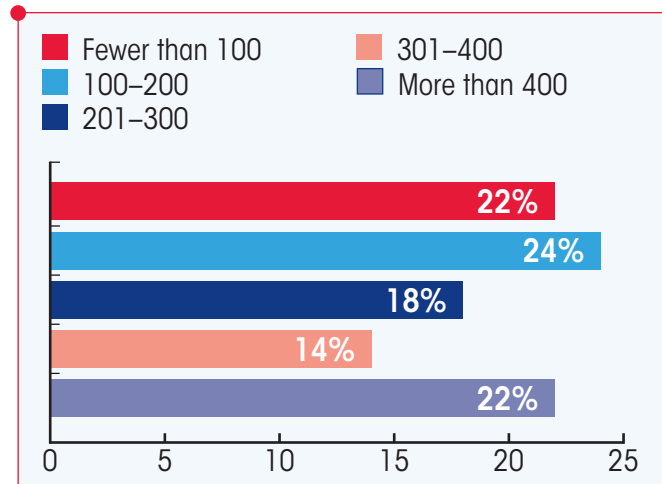
Are you from a prospective payment system (PPS) hospital or a critical access hospital (CAH)?



## Providers vary in size once again

When it comes to the size of our respondents' facilities, there has been much fluctuation over the past few years. Last year, providers with more than 400 beds were the majority, while this year it was providers with 100–200 beds at 24%. The overall responses were evenly distributed, however, as providers with more than 400 beds and providers with fewer than 100 beds both came in at 22%. <sup>n</sup>

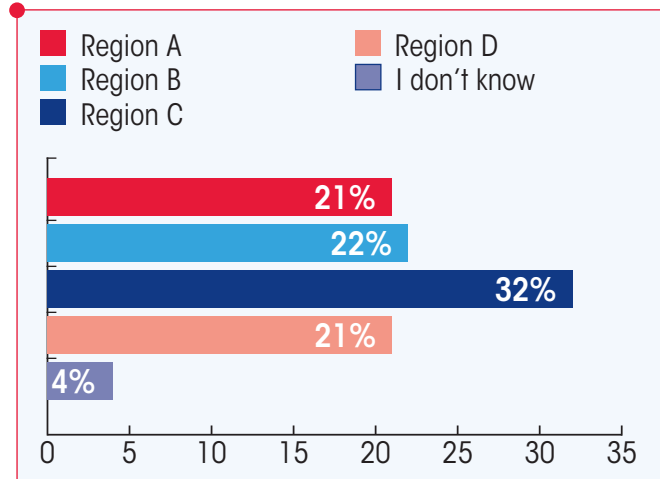
What is your facility's bed size?



## Solid representation from all four RA regions

In what has been a relatively steady trend, Region C, Connolly, still had the largest representation (32%) while Region B, CGI, came in second at 22%. Region A, Performant Recovery, and Region D, HealthDataInsights, nearly tied once again, as they both hovered around the 21% mark. It comes as no surprise that Region C had the highest representation based on the size of the region and the intensity of the RA reviews at the beginning of the program. What is interesting is that CGI, one of the slower RAs to post approved issues, has the second highest number of respondents in this survey. <sup>n</sup>

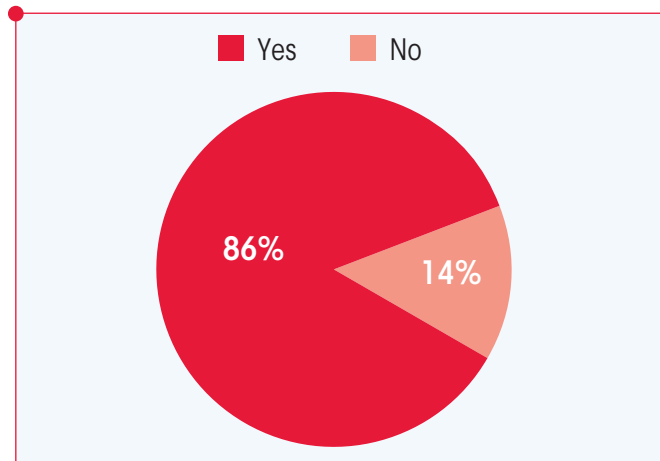
What Recovery Auditor region are you located in?



## No surprises: Recoupments from automated reviews up

In the past three benchmarking reports, the providers who have seen an RA recoupment related to an automated audit have increased from 40% to 72%, and finally to 86% this year. As RA activity continues to grow along with automated reviews, this should not come as a surprise to anyone. <sup>n</sup>

Have you had recoupments related to an automated audit?

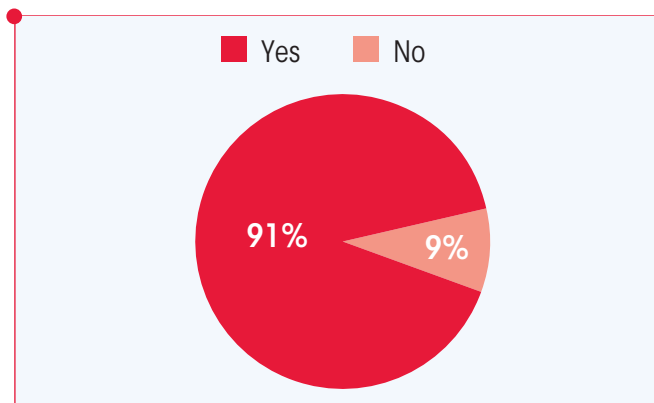


## Complex and semi-automated reviews

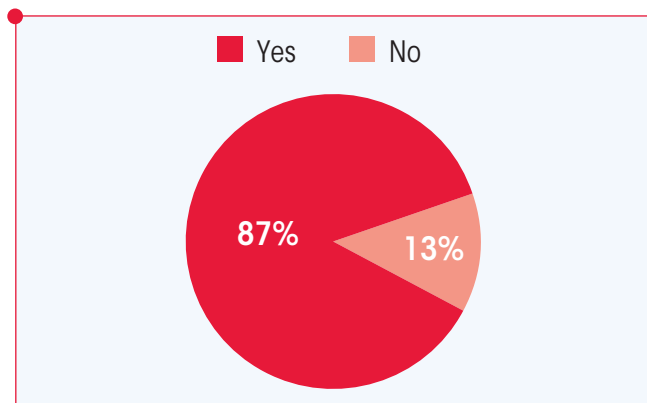
The percentage of respondents who have received record requests for complex or semi-automated reviews has gone up a bit this year. The data shows that 91% of respondents have received one, while 87%

have had recoupments from them. Last year, 82% had received record requests while 76% had seen recoupments. As the RA program grows, this kind of increase should not come as a shock. <sup>n</sup>

Have you had a record request for a complex or semi-automated review?



Have you had recoupments from complex or semi-automated reviews?

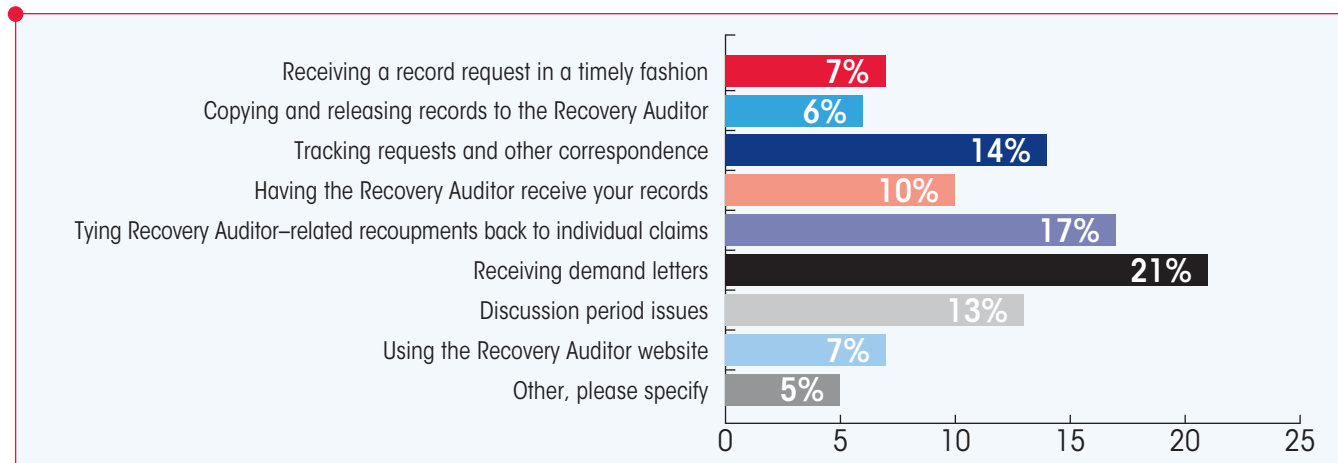


## Operational issues: What's troubling providers?

When it comes to issues that survey takers had difficulty with in 2012, the answers were almost identical to the previous year's survey: Twenty-one percent of respondents, just like in 2011, agreed that demand letters provide the most hassle when it comes to RAs. Associating RA-related recoupments with individual claims came

in a close second at 17%, the same amount as last year. Right behind that at 14% was tracking requests and other correspondence—once again, the same percentage as the previous year. The issue in the list that gave providers the least amount of difficulty (6%) was copying and releasing records to the RA. <sup>n</sup>

What has your experience been with the Recovery Auditor process in general? Have you had difficulty with the following (please check all that apply):

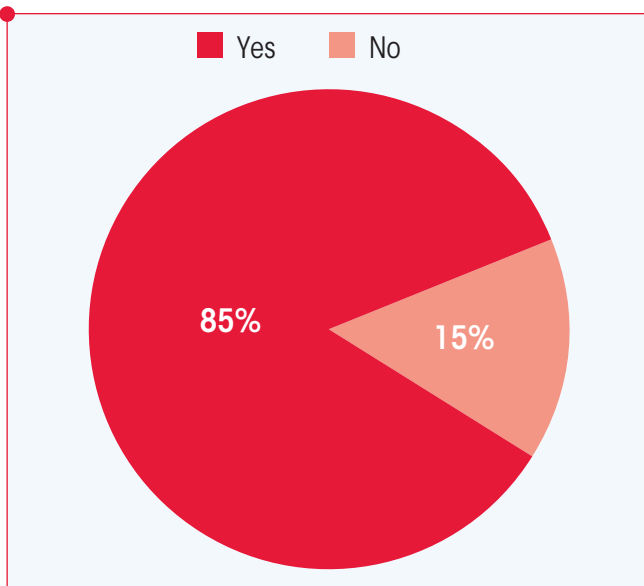


## Moving toward a consolidated audit team

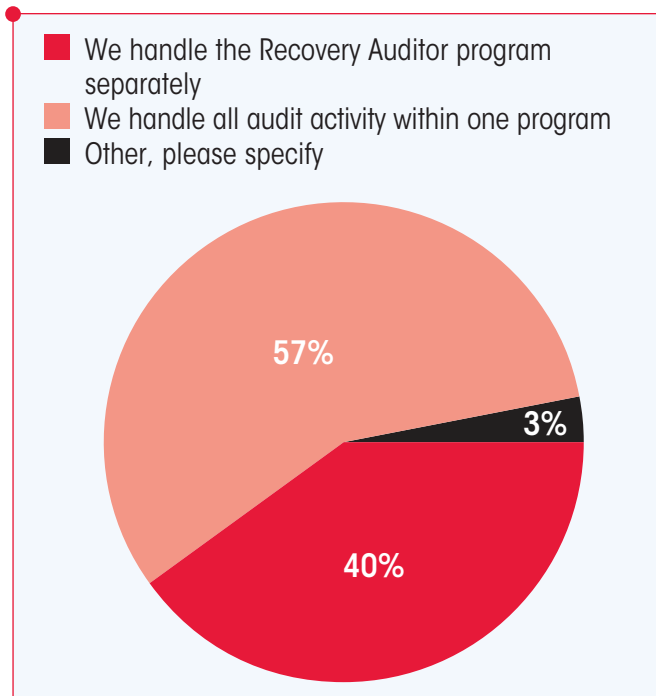
Not surprisingly, this year's survey shows that 85% of respondents have a formal RA program in place, compared to 82% last year. One trend worth noting is that providers are moving toward unified audit programs. Last year, 49% of survey takers said that they

include all activity under one group, but of the 6% that chose "other," many indicated that they were moving toward consolidation. This year validates that trend, as 57% now say that all of their audit activity is handled by the same group. <sup>n</sup>

Do you have a formal, internal Recovery Auditor program in place?



Is your Recovery Auditor program part of a larger program to handle government audits, or do you handle them separately?



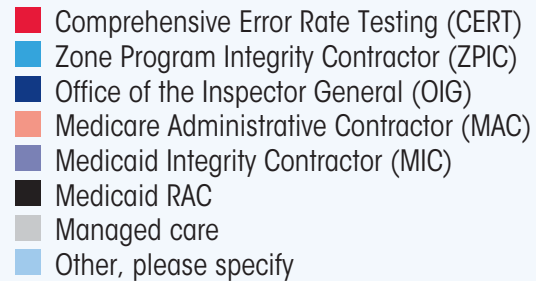


## Additional audit activity

Based on what we have seen this past year, it makes sense that Medicare Administrative Contractor (MAC) audits would be a lot more prevalent than in last year's survey, when only 16% had seen activity from their MAC, and that was definitely the case. MAC audits were tied with Comprehensive Error Rate Testing (CERT) for the largest percentage of respondents (22% each); last year CERT had the lion's share of responses at 35%.

Zone Program Integrity Contractor audits and Medicaid RAC audits are experienced the least, at 6% each. Of those who indicated "other," most of them said that they've seen commercial audits at their facility, which we can presume will continue to rise as an industry trend. <sup>n</sup>

### What other audits have you experienced at your facility?

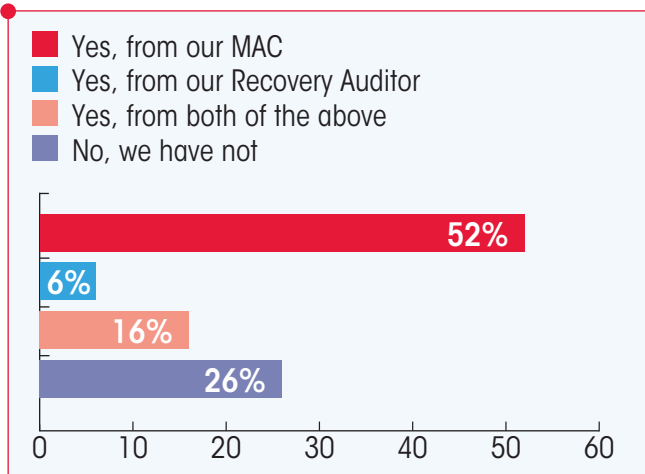


## Prepayment reviews arrive

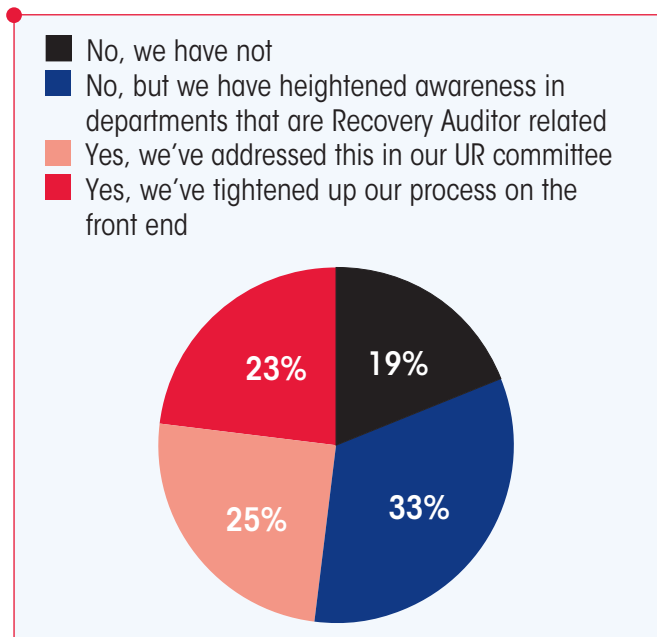
With the announcement and launch of the RA prepayment reviews this past year, the level of prepayment activity specifically pertaining to the RAs is low, at 6%. That doesn't mean, however, that providers are new to prepayment review, as 52% have seen prepayment reviews from their MAC, and a total of 74% have seen them either from their MAC, their RA, or both. I expect this number will be even higher next year, so providers should keep an eye on this activity.

Providers are relatively split when it comes to their internal preparation for these reviews. A total of 52% of respondents said that they are not specifically changing any internal processes as a result of prepayment reviews, but 33% of those did say that they have heightened awareness in RA-related departments. On the other hand, 48% said that they *have* changed something internally, with 25% saying that they've addressed the issue of prepayment reviews in the utilization review (UR) committee, and 23% tightening up the process on the front end. <sup>n</sup>

### Have you experienced prepayment audits?



### Have you changed any internal processes based on the announcement of prepayment reviews?

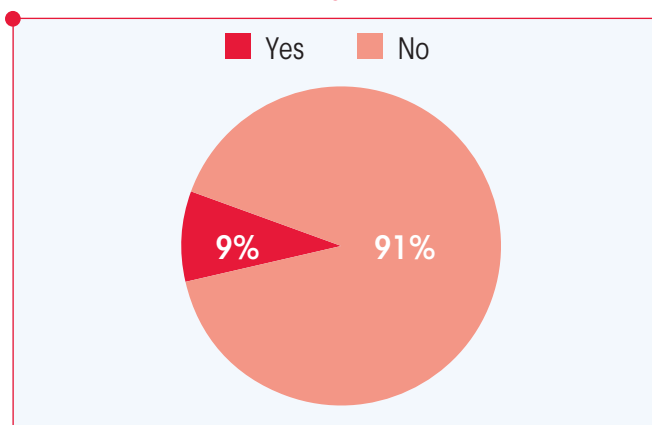


## Part A to Part B rebilling demonstration

Twenty-eight (9%) of our respondents for this question indicated that their facility is one of the 380 hospitals participating in the Part A to Part B rebilling demonstration.

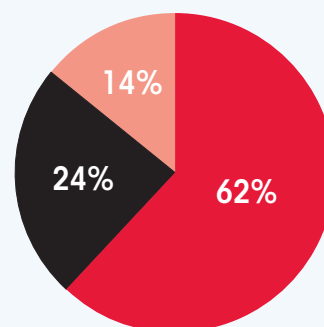
Of those respondents, the majority (62%) have been able to rebill and get reimbursed, while 14% have not rebilled any claims but plan on doing so in the future. <sup>n</sup>

Are you one of the hospitals participating in the Part A to Part B rebilling demonstration?



If yes, what has your experience been thus far?

- We have been able to rebill and get reimbursed
- We have rebilled but are waiting to hear back
- We have not rebilled any claims yet, but plan on doing so

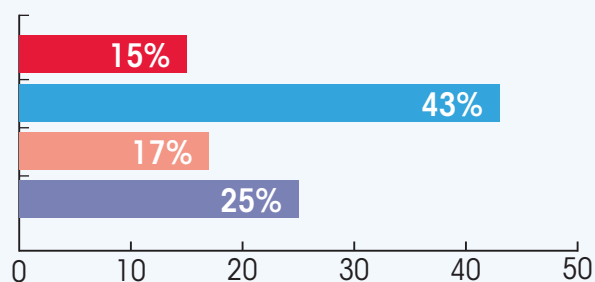


## Impact of the American Hospital Association lawsuit

The American Hospital Association (AHA) has filed a lawsuit against RAs for unfair Medicare practices, but the question is, what will come of it? Sixty percent of survey respondents seem to think that *something* will happen, but 43% of those think only minor changes will result. On the other side, 17% think that nothing will come of the lawsuit; meanwhile, 25% are simply happy to see the RAs be called out for their actions. <sup>n</sup>

Do you think that anything will come of the recent lawsuit that the American Hospital Association filed against HHS for unfair Medicare practices pertaining to the Recovery Auditor program?

- Yes, I think that the Recovery Auditors will be forced to make major changes
- Yes, I think that the Recovery Auditors will be forced to make some minor changes, but don't expect them to be substantive
- No, I don't think that anything will come of it
- My only thought here is: It's about time!



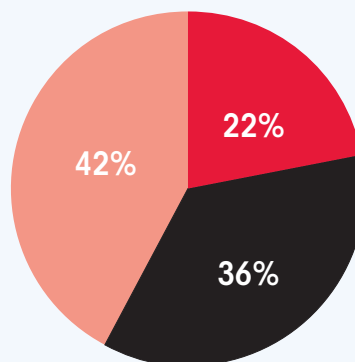
## Departmental representation on the RA team

When it comes to which departments are represented on the RA team, respondents had a wide range of answers. Fourteen percent of respondents (the largest share) have medical records/HIM employees on the team. Tied at 13% each were coding staff members and case management staff members. Also tied, at 12%, were compliance professionals and patient accounting representatives. Coming in at less than 10% were the remaining departments: physicians, legal professionals, patient access professionals, chargemaster department members, outside consultants, and UR physician advisors. Only 3% indicated something outside the provided options.

Of the represented departments, director-level staff members were the most represented at 42%, while managerial-level members made up 36% of the respondents. Only 22% of those who responded had staff-level members on their RA teams. <sup>n</sup>

### What level do your participating Recovery Auditor team members come from?

- Staff level
- Managerial level
- Director level



## More facilities using a dedicated RA coordinator

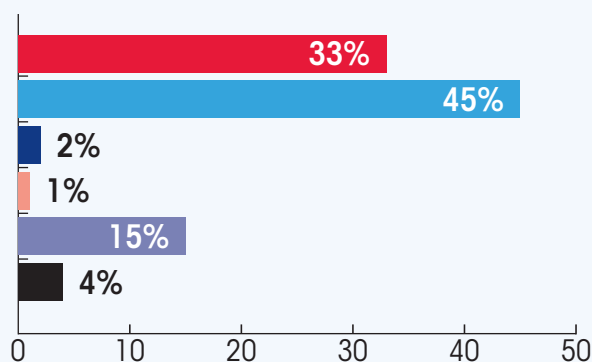
Again, as the RA program continues to grow, so must the preparation. In last year's survey, a total of 67% indicated that they have some form of a dedicated RA coordinator on staff. In this year's survey, 81% of respondents said they utilize a coordinator, 45% of which hold additional jobs or responsibilities within the facility.

Interestingly, some facilities (33%) have an employee whose sole responsibility is the RA program, while 15% of respondents have no coordinator at all.

Of those using a dedicated coordinator for their RA program, 29% indicated that this person has an HIM/coding background. Case management/nursing professionals had the next highest representation at 21%, while patient accounting backgrounds only made up 9% of responses. <sup>n</sup>

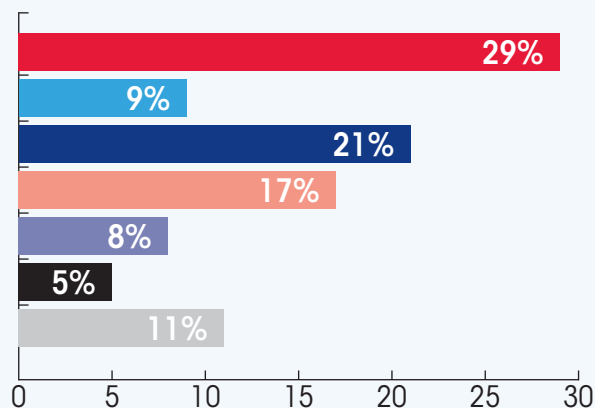
### Do you have a dedicated Recovery Auditor coordinator?

- Yes, we have a full-time employee dedicated to Recovery Auditor coordination
- Yes, but our coordinator holds additional jobs/responsibilities within the facility
- Yes, we have a part-time employee
- Yes, we have an outside consultant
- No, we don't have one
- Other, please specify



### What is your Recovery Auditor coordinator's background?

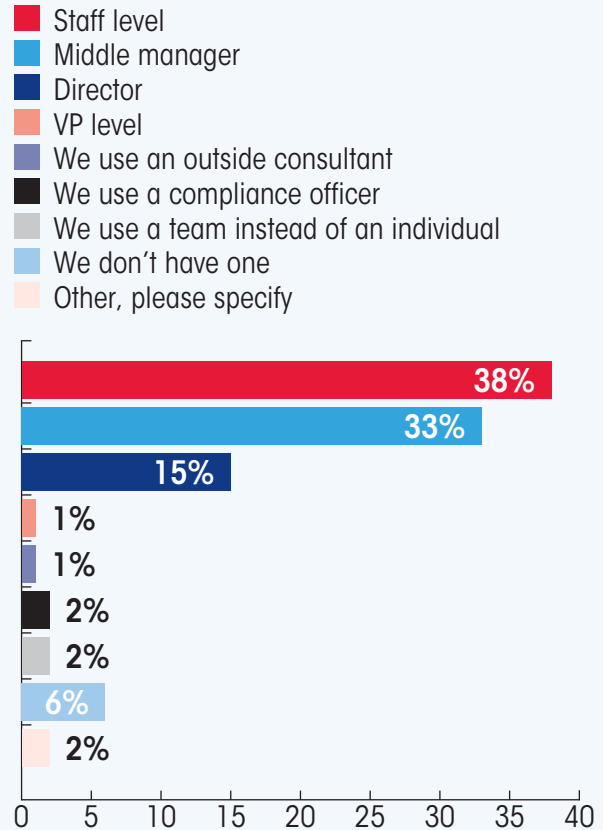
- HIM/coding
- Patient accounting
- Case management/nursing
- Compliance
- Finance/business
- We don't have a Recovery Auditor coordinator
- Other, please specify



## Varying staff levels for the role of coordinator

This is interesting: In the departmental representation question presented earlier, 42% of the represented RA department members were director level. In this section, though, respondents indicated that the person who is their RA coordinator is most often (38%) a staff-level employee, with middle management coming in at a close second (33%). Director-level employees made up just 15% of the responses. Perhaps the idea here is to have director-level involvement to maintain awareness, while allowing the staff-level member to handle the process itself. <sup>n</sup>

### What is the level of your Recovery Auditor coordinator?

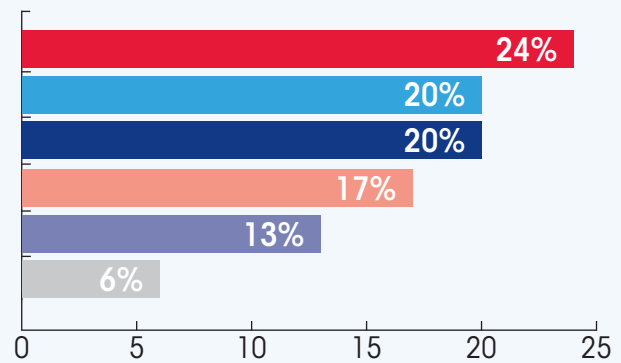


## Physician involvement on the team

Even more so than last year (81% compared to last year's 67%), providers are using physicians on their team. The role of the physician, however, once again varies. By a slim margin (24%), respondents indicated that their physician's main role is to review denied inpatient cases. Next up were helping to educate other physicians about denied cases, and helping to formulate appeals (both at 20%). Essentially, respondents have indicated that their physicians are being used in multiple ways. The increase in physician involvement is very promising and supports the team approach to increased audit scrutiny. <sup>n</sup>

If your Recovery Auditor team includes a physician, how is he or she involved? (Check all that apply)

- He or she reviews denied inpatient cases
- He or she helps educate other physicians about denied cases
- He or she helps formulate appeals
- He or she regularly sits on the Recovery Auditor team
- Our Recovery Auditor team doesn't include a physician
- Other, please specify



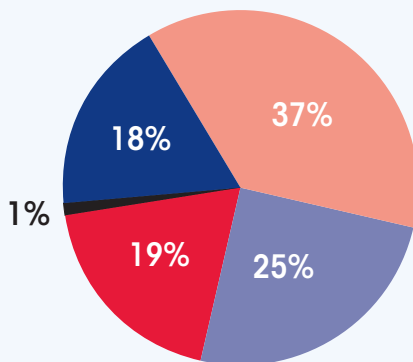
## Individual departments still absorbing costs into budget

For the most part, providers do not seem to have a separate budget for RA preparation and management; only 18% indicated that they do. Once again, the majority of the providers who took this survey (37%) indicated that each department is involved in absorbing the costs into its budget. Providers who do not have a budget set aside made up 25% of the responses, while 19% were unsure whether they had a separate budget.

Of those folks who do have a separate budget, the amount of money varies across the board. A budget of \$50,000–\$99,000 was the range of money that most providers (33%) had set aside. Interestingly, the next highest response total came from those who had \$250,000 or more set aside, at 22%. Rounding out the top three were those who had set aside up to \$49,000, at 17%. <sup>n</sup>

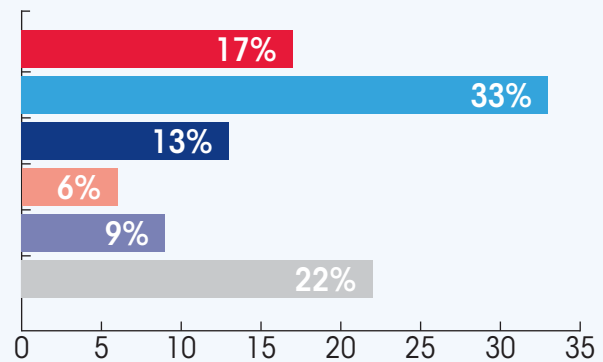
**Do you have a specific budget set aside for Recovery Auditor preparation and management, or is each department absorbing it into their budgets?**

- We have a budget set aside for Recovery Auditor preparation and management
- Each department involved is absorbing the costs into their budget
- We do not have a budget set aside for Recovery Auditor preparation and management
- I don't know
- Other, please specify



**If you do have a separate budget, how much money is set aside?**

- \$0–\$49,000
- \$50,000–\$99,000
- \$100,000–\$149,000
- \$150,000–\$199,000
- \$200,000–\$249,000
- \$250,000 or more (if more, please specify)





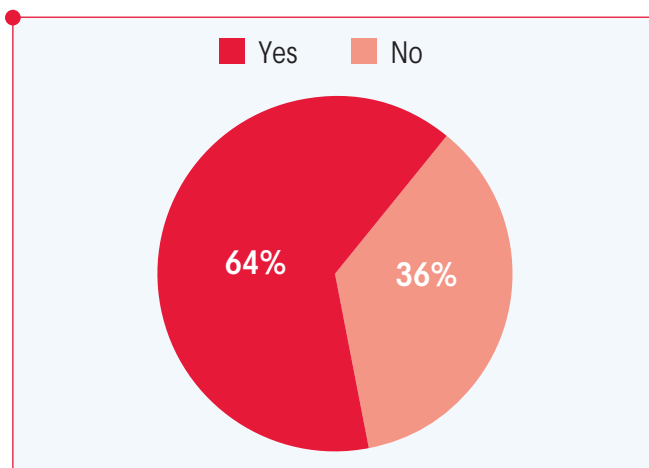
## More providers keeping a reserve fund

The amount of providers that are keeping a reserve fund set aside in case of possible recoupment continues to rise. This year, the number of folks who answered “yes” jumped from 52% to 64%, an indication that more and more providers are trying to avoid getting caught off guard by large-sum recoupments.

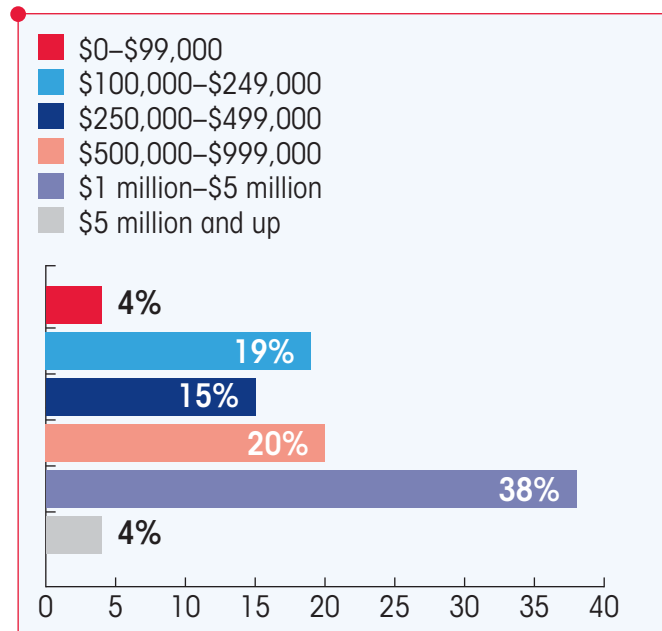
The middle ranges (starting with \$100,000 and ending at \$999,999) make up a majority (54%) of the answers,

with only 4% of respondents keeping \$99,000 or less, or \$5 million or more. Somewhat surprising, though, is that fully 38% of those who keep a reserve keep between \$1 million and \$5 million. This is a large sum of money that may indicate several concerns by providers—RA issues and processes continuing to grow without restraint, providers being unable to fully comply on a day-to-day basis with complex regulations, or both. <sup>n</sup>

Do you have a reserve fund set aside in anticipation of possible recoupment?



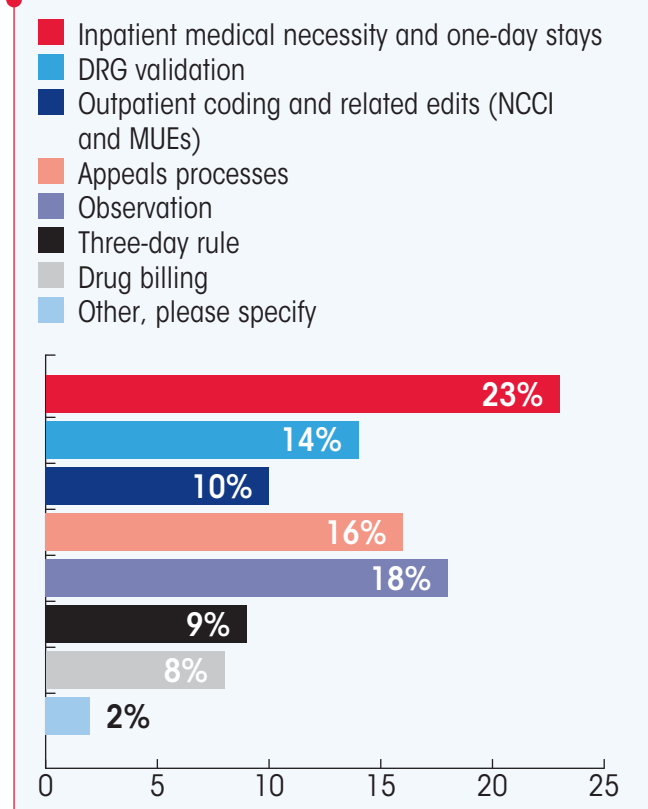
If you do have a reserve fund, how much money is set aside?



## The song remains the same: Provider focus areas

As most of you probably expected, the top focus area when it comes to preparing against RAs, according to survey respondents, was inpatient medical necessity and one-day stays, at 23%. The next two, which also made the top three last year, were observation at 18% and the appeals process at 16%. Drug billing, at 8%, was once again the least of survey takers' concerns. That said, although it came in last place, the OIG and RAs continue to recoup large sums of money in the area of drug billing, which can be a complex issue when the pharmacy department has to communicate through the chargemaster and convert its billing information into the units of service of the HCPCS code. Providers should not let their guard down in this area. <sup>n</sup>

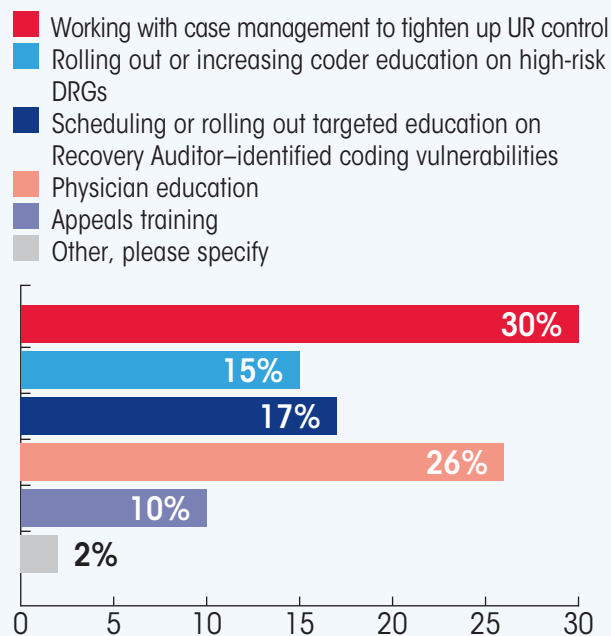
We have identified or plan to address the following areas as part of our preparations against Recovery Auditors:



## Respondents: Case management and physician education most important areas

Concerning the focus areas presented earlier, providers who took the survey indicated that working with case management to tighten up UR control (30%) and physician education (26%) are the two most important areas when it comes to taking specific, proactive action against RAs. Seventeen percent of respondents said that scheduling or rolling out targeted education on RA-identified coding vulnerabilities was their top concern. Those who cited appeals training as the most important area came in at 10%. <sup>n</sup>

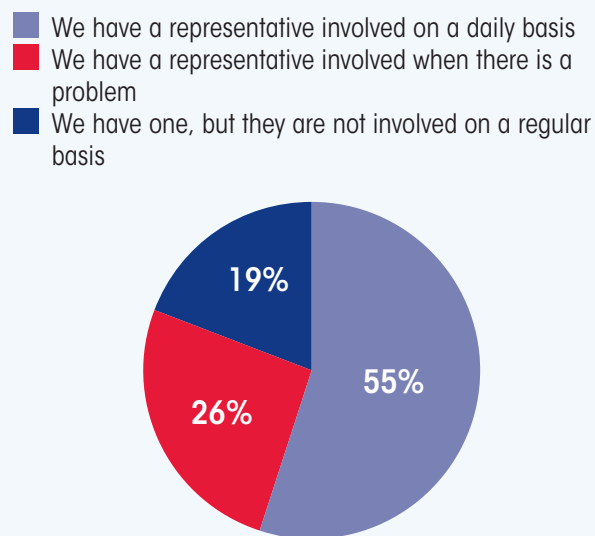
Have these areas caused you to take specific action, and if so, what? (Check all that apply)



## UR committee involvement with medical necessity determinations

It seems that respondents for this year's survey have grasped the importance and proper use of a UR committee, as 55% indicated that they have a UR representative involved with medical necessity determinations on a daily basis. Only 19% said their UR committee is not regularly involved, while 26% seem to have a representative available to them as situations arise. In last year's survey, a whopping 13% of respondents indicated that they did not have a UR committee. <sup>n</sup>

Do you have a UR committee that is actively involved in inpatient medical necessity determinations?

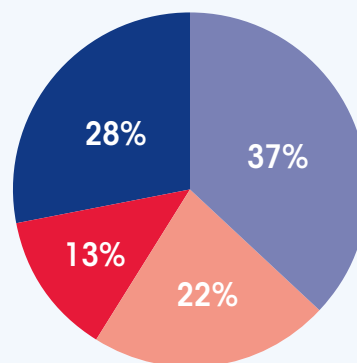


## Physician advisor usage on the rise

In last year's survey, 19% of respondents said that they were not using a physician advisor. This year, that number has decreased to 13%. There are a few notable trends here, as well: This year, only 37% of respondents are using an internal physician advisor, compared to 43% last year. This can be offset by the fact that the use of both external advisors has gone from 18% to 22%, and the use of a combination of the two has gone from 25% to 28%. <sup>n</sup>

### Do you have an internal or external physician advisor?

- Yes, an internal physician advisor
- Yes, an external physician advisor
- No
- We have a combination of both



## Tracking software: More providers using third-party vendors

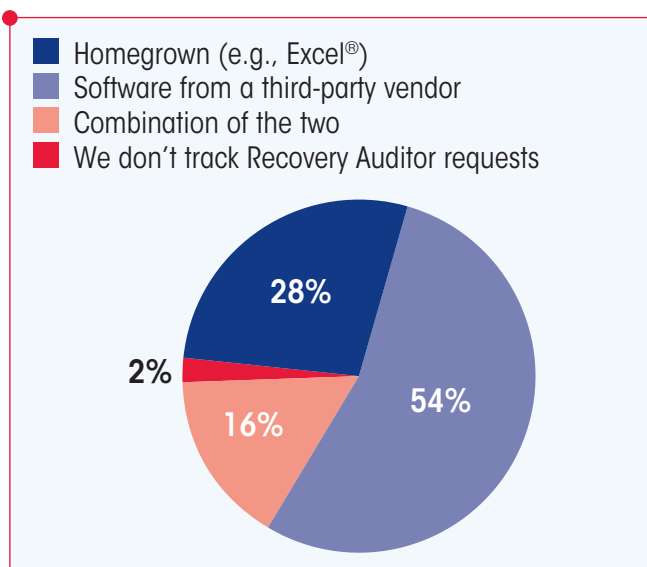
Fifty-four percent of respondents in this year's survey indicated that they use software from a third-party vendor to track and manage RA requests, up from 46% last year. All of the remaining options saw a decrease in percentages, including a 1% drop in those who do not track their RA requests at all. (And for those folks, here is a hint: You should!)

Of the 172 respondents who use third-party software, the most popular choice was AHA RACTrac at

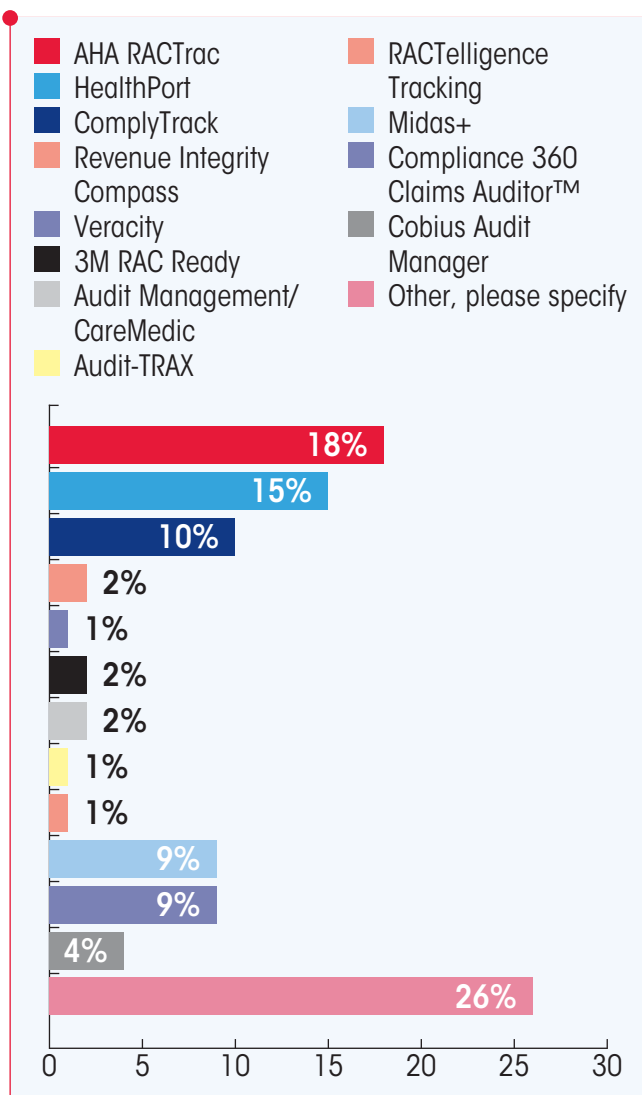
18%, followed by HealthPort at 15%. Of those who chose "other," some of the popular responses included Craneware, MedAssets, Wellington Audit Navigator, and Executive Health Resources.

Also of note is that 59% of those who track RA activity with software indicated their product is compatible with AHA RACTrac. [n](#)

To manage and track Recovery Auditor requests, what type of tool do you use?



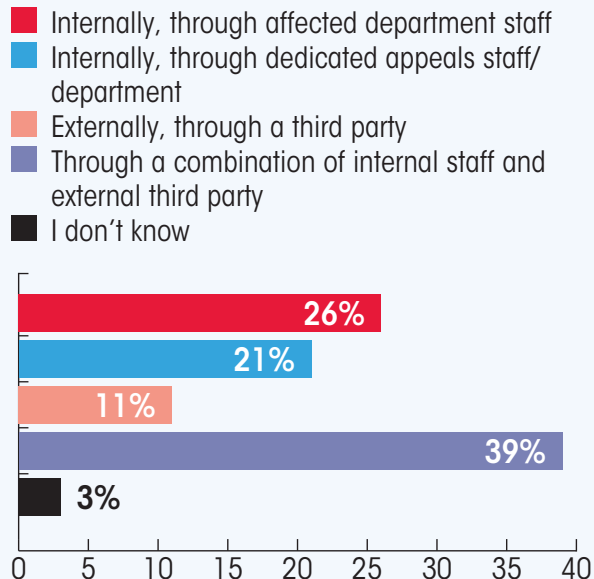
What vendor did you use to assist with any of the above areas?



## How are you handling appeals?

Last year, providers were split relatively evenly between using a combination of internal and external resources to handle appeals (35%) and handling them internally through affected departments (34%). This year, respondents have indicated that they are using a combination of internal staff and external third-party resources more often, with 39% having selected this option. Twenty-six percent of respondents are handling appeals internally, through affected staff, while 21% are using a dedicated appeals staff/department. <sup>n</sup>

### How are you handling your Recovery Auditor appeals program?

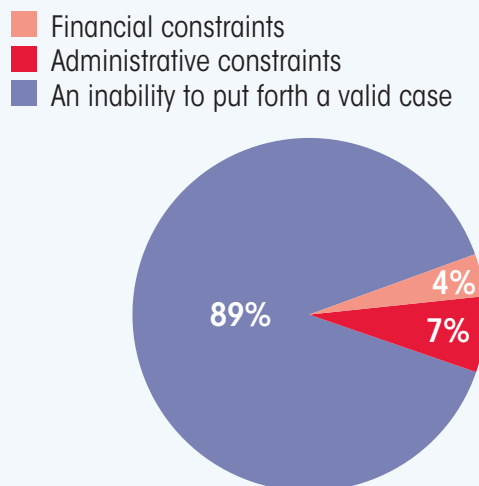


## Provider motive behind a non-appeal

These results were interesting, as I had expected financial or administrative constraints to have much higher representation as reasons for not appealing. A staggering 89%, however, cited an inability to put forth a valid case as the main motive for not appealing a denial. Only 4% of respondents indicated that financial constraints were behind a non-appeal.

With audit activity increasing at all levels over the past few years, increased accessibility of regulations and CMS guidance through online resources, and increased awareness of documentation improvement at all levels, in theory there should be far fewer respondents claiming an inability to formulate a valid case for appeal. Providers should take note. <sup>n</sup>

### What has been your main reason for not appealing a denied case?

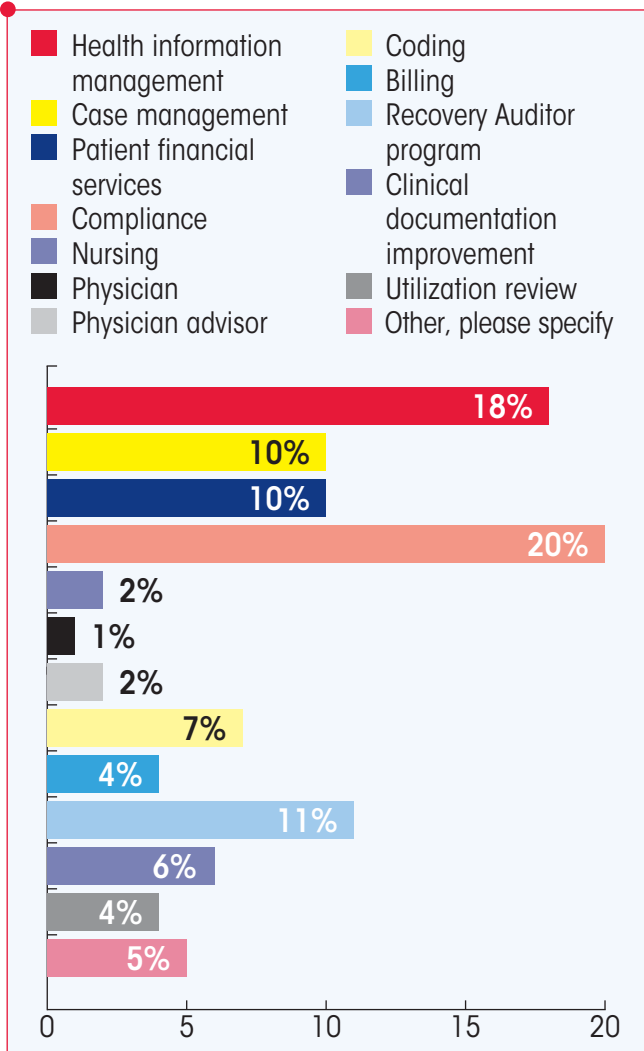


## So, who are our survey respondents?

Based on the results of this question, the departments with the most representation in our audience were compliance (20%) and HIM (18%). RA team representatives made up 11%, while case management and patient financial services came in at 10% each. The group with the least amount of representation in this survey was physicians, at 1%. Some of the groups that came up a number of times in the “other” category were clinical documentation, revenue integrity, and quality.

The professional level of our survey takers also varied, but mainly ranged from staff to director level. Staff-level respondents made up 34% of the audience, while manager-level and director-level respondents came in at 33% and 29%, respectively. Only 1% of respondents were president or CEO of their facility. <sup>n</sup>

Which department/role are you most closely associated with at your facility?



What is your professional level?

