MOCK RAC Audit Checklist

1. **Record Preparation**
    a. RAC Tracker is initiated by CFO- on share drive- team knowledgeable- HIM fills in dates as records are sent, etc.
    b. Printing of Chart/Placing Chart on CD
2. **Review of Record**
    a. Assemble RAC team to review record.
        i. Review forms for multiple blanks- critical decisions on whether to include certain forms or better off using progress notes.
        ii. Number pages
    b. Recommend that CFO/BOM (non-clinical) do the following audits to give an objective point of view to strengths/weaknesses of chart- similar to actual RAC auditors
        i. Medical Necessity Audit
        ii. IRF 2010 Rule Audit
    c. Team to review each of the admission criteria and write down items from the medical record that justify coverage criteria in preparation for having to write an appeal. Important things to remember when finding supporting documentation:
        i. **Focus on Safety**- does it mention in the chart that patient is unsafe secondary to physical or cognitive limitations. This helps justify need for more intensive level of care and 24 hour nursing supervision.
        ii. **Cognitive Problems**- Does your speech department screen for cognitive problems if there is a history of falls or mention in the chart of decreased memory or other mild cognitive problems? If you have a patient with a CMI <1.0 (typical orthopedic patient) that has documentation re: safety, needing cues, mild memory, etc. A **cognitive screening** can be strong supporting documentation to justify need for 24 hour nursing, coordinated interdisciplinary team, and intense level of therapies. Even if the patient does not qualify for speech therapy, if there are mild or inconsistent cognitive problems a screening followed by compensatory strategies and recommendations by the speech pathologist to the treatment team to utilize as part of the plan of care supports justification.
        iii. **Standardized testing results**- anytime you can show scores from standardized test that are below functional limits it supports justification of admission. Don't forget scores built into Nursing Assessment such as: **Morse Fall Risk** Assessment and **Braden Scale** in addition to tests done by PT, OT, and Speech.
        iv. **Patients' with CMI less than 1.0-** Since these patients tend to be shorter lengths of stay and more difficult to justify the need for intense level of rehab services, and significant practical improvement it is important to focus on the discharge destination, patient/family training that needed to be done in an intensive setting and how the team's primary goal was a community discharge. This can be accomplished by focusing on:

1. Case Management completing the **Patient Planning Discharge Checklist** (DC Toolkit) with Patient and Family
2. **Home Evaluation Checklist** (DC toolkit)

These are good tools to help support coverage criteria in all patients but even more important with those that have low CMI's and short lengths of stay.

3. **Other Considerations:**
   a. **CMG- 3 day outlier-** BO needs to use 3 day outlier even if it takes 4 days to discharge a patient if it was identified at time of admission that the patient was not appropriate for rehab once admitted.
   b. **Recoupment Code on Remittance-** BO needs to check remittances on EOB's to verify if any recoupment secondary to RAC audit is being taken.
   c. **Signature Requirements- Medicare Program Integrity Manual, Chapter 3, Section 3.2.1.1.B.c**

Reliant
Tracey Nixon
Reliant Hospital Partners
VP/ Chief Compliance Officer
(972) 308-8567 Work
(214) 208-5665 Mobile
tnixon@relianthcp.com
15851 Dallas Parkway, Suite 500
Addison, TX 75001
www.relianthcp.com