

Recovery Audit Contractors (RACs) and Medicare

The Who, What, When, Where,
How and Why?

Developed by the RAC and distributed to
National Government Services by the Centers
for Medicare & Medicaid Services (CMS)

Agenda

- **What is a RAC?**
- **Will the RACs affect me?**
- **Why RACs?**
- **What does a RAC do?**
- **What are the providers' options?**
- **What can providers do to get ready?**

What is a RAC?

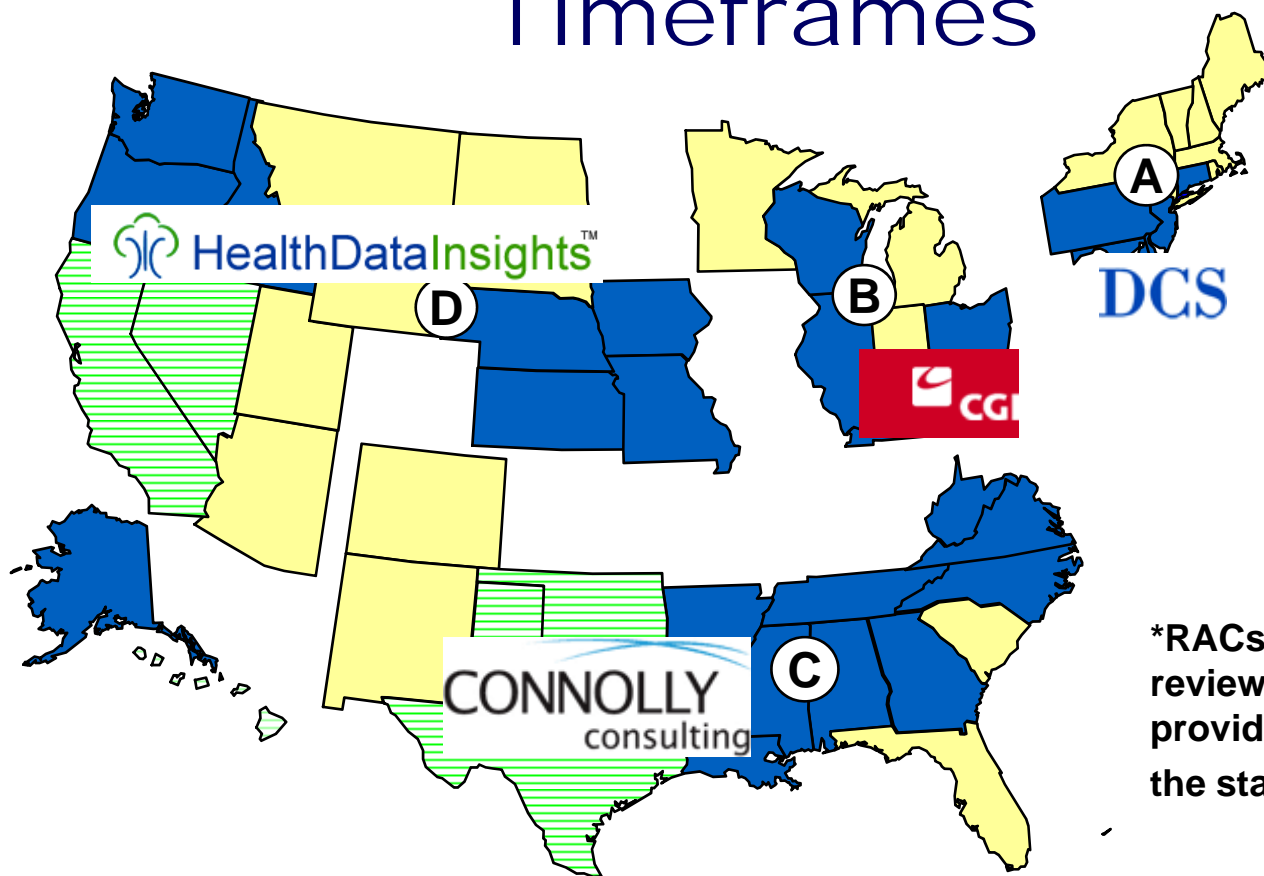
The RAC Program Mission

- The RACs detect and correct **past** improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent **future** improper payments
 - **Providers** can avoid submitting claims that do not comply with Medicare rules
 - **CMS** can lower its error rate
 - **Taxpayers** and future Medicare beneficiaries are protected

Will the RACs affect me?

- **Yes, if you bill fee-for-service programs, your claims will be subject to review by the RACs**
- **If so, when?**

Timeframes

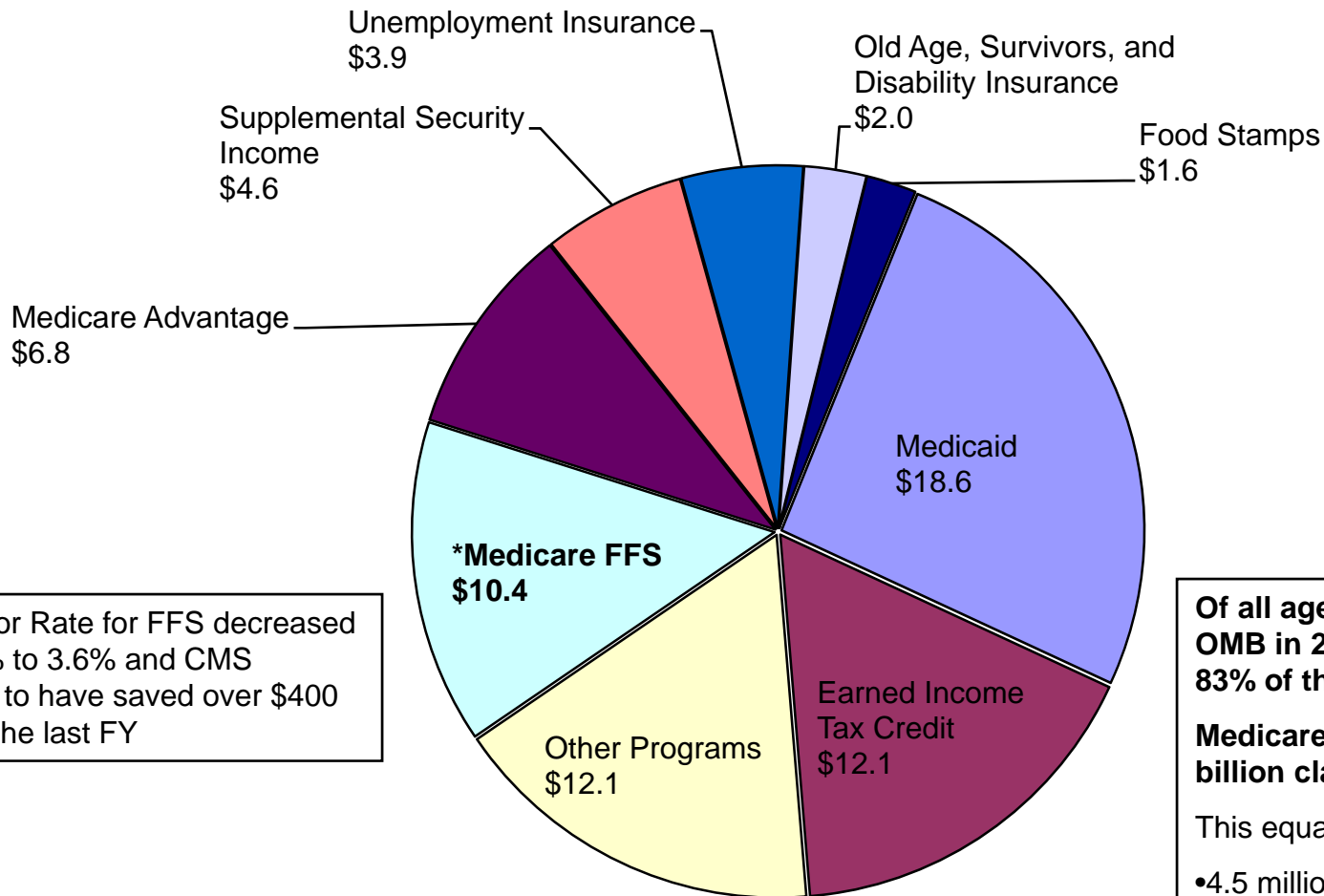


*RACs may not begin reviewing until there is provider outreach in the state

Claims Available for Analysis	Provider Outreach	Earliest Correspondence
March 1, 2009	March 1, 2009	March 1, 2009
March 1, 2009	March 1, 2009	March 1, 2009
August 1, 2009	August 1, 2009	August 1, 2009

Why do we have RACs?

Top Federal Programs with Improper Payments 2008 (Billion Dollars)



*2008 Error Rate for FFS decreased from 3.9% to 3.6% and CMS estimates to have saved over \$400 million in the last FY

Of all agencies that reported to OMB in 2008, these 8 make up 83% of the improper payments.

Medicare receives over 1.2 billion claims per year.

This equates to:

- 4.5 million claims per work day

RAC Legislation

- **Medicare Modernization Act, Section 306**
 - Required the three-year RAC demonstration
- **Tax Relief and Healthcare Act of 2006, Section 302**
 - Requires a permanent and nationwide RAC program by January 1, 2010
- **Both of these statutes gave CMS the authority to pay the RACs on a contingency fee basis**

What does a RAC do?

RAC Review Process

- **RACs review claims on a post-payment basis**
- **RACs use the same Medicare policies as Carriers, FIs and MACs**
 - **NCDs, LCDs, CMS Manuals**
- **Two types of review:**
 - **Automated (no medical record needed)**
 - **Complex (medical record required)**
- **RACs will not be able to review claims paid prior to October 1, 2007**
 - **RACs will be able to look back three years from the date the claim was paid**
- **RACs are required to employ a staff consisting of nurses or therapists, certified coders, and a physician CMD**

The Collection Process

- **Same as for Carrier, FI, and MAC identified overpayments**
- **Carriers, FIs, and MACs issue Remittance Advice**
 - Remark Code N432: “Adjustment Based on Recovery Audit”
 - **Carrier, FI, and MAC recoups by offset unless provider has submitted a check or a valid appeal**

What is different?

- **Demand letter is issued by the RAC**
- **RAC will offer an opportunity for the provider to discuss the improper payment determination with the RAC (this is outside the normal appeal process)**
- **Issues reviewed by the RAC will be approved by CMS prior to widespread review**
- **Approved issues will be posted to a RAC Web site before widespread review**

What are Providers' Options

- **Pay by check**
- **Allow recoupment from future payments**
- **Request or apply for extended repayment plan**
- **Appeal**
 - **Appeal Timeframes**
 - <http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf>
 - **935 MLN Matters**
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf>

RAC Program's Three Keys to Success

- **Minimize Provider Burden**
- **Ensure Accuracy**
- **Maximize Transparency**

Minimize Provider Burden

- **Limit the RAC “look back period” to three years**
 - Maximum look back date is October 1, 2007
- **RACs will accept imaged medical records on CD/DVD**
- **Limit the number of additional documentation requests**

Summary of Additional Documentation Request Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, and Hospice**
 - 10 percent of the average monthly Medicare claims (max 200) per 45 days per NPI
- **Other Part A Billers (HH)**
 - One percent of the average monthly Medicare episodes of care (max 200) per 45 days per NPI

Summary of Additional Documentation Request Limits (for FY 2009)

- **Continued...**

- **Physicians (including podiatrists, chiropractors)**

- Sole Practitioner: 10 medical records per 45 days per group NPI
- Partnership two to five individuals: 20 medical records per 45 days per group NPI
- Group 6-15 individuals: 30 medical records per 45 days per group NPI
- Large Group 16+ individuals: 50 medical records per 45 days per group NPI

- **Other Part B Billers (DME, Lab, Outpatient hospitals)**

- One percent of the average monthly Medicare services (max 200) per NPI per 45 days

Additional Documentation Limit Example

- **Outpatient Hospital**
 - **360,000 Medicare paid services in 2007**
 - **Divided by 12 = average 30,000 Medicare paid services per month**
 - **x .01 = 300**
 - **Limit = 200 records/45 days (hit the max)**

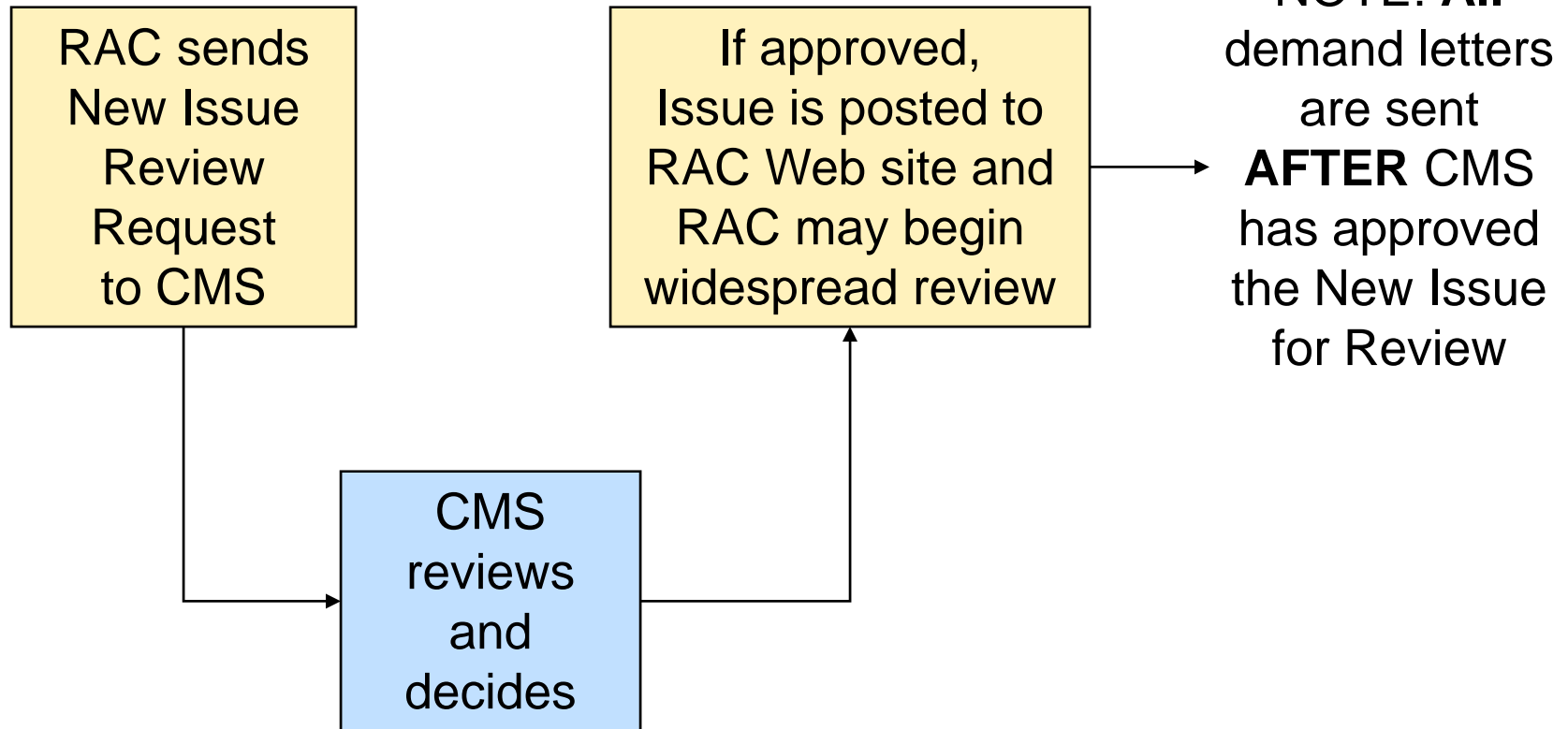
Ensure Accuracy

- **Each RAC employs:**
 - Certified coders
 - Nurses and/or Therapists
 - A physician CMD
- **CMS' New Issue Review Board provides greater oversight**
- **RAC Validation Contractor provides annual accuracy scores for each RAC**
- **If a RAC loses at any level of appeal, the RAC must return the contingency fee**

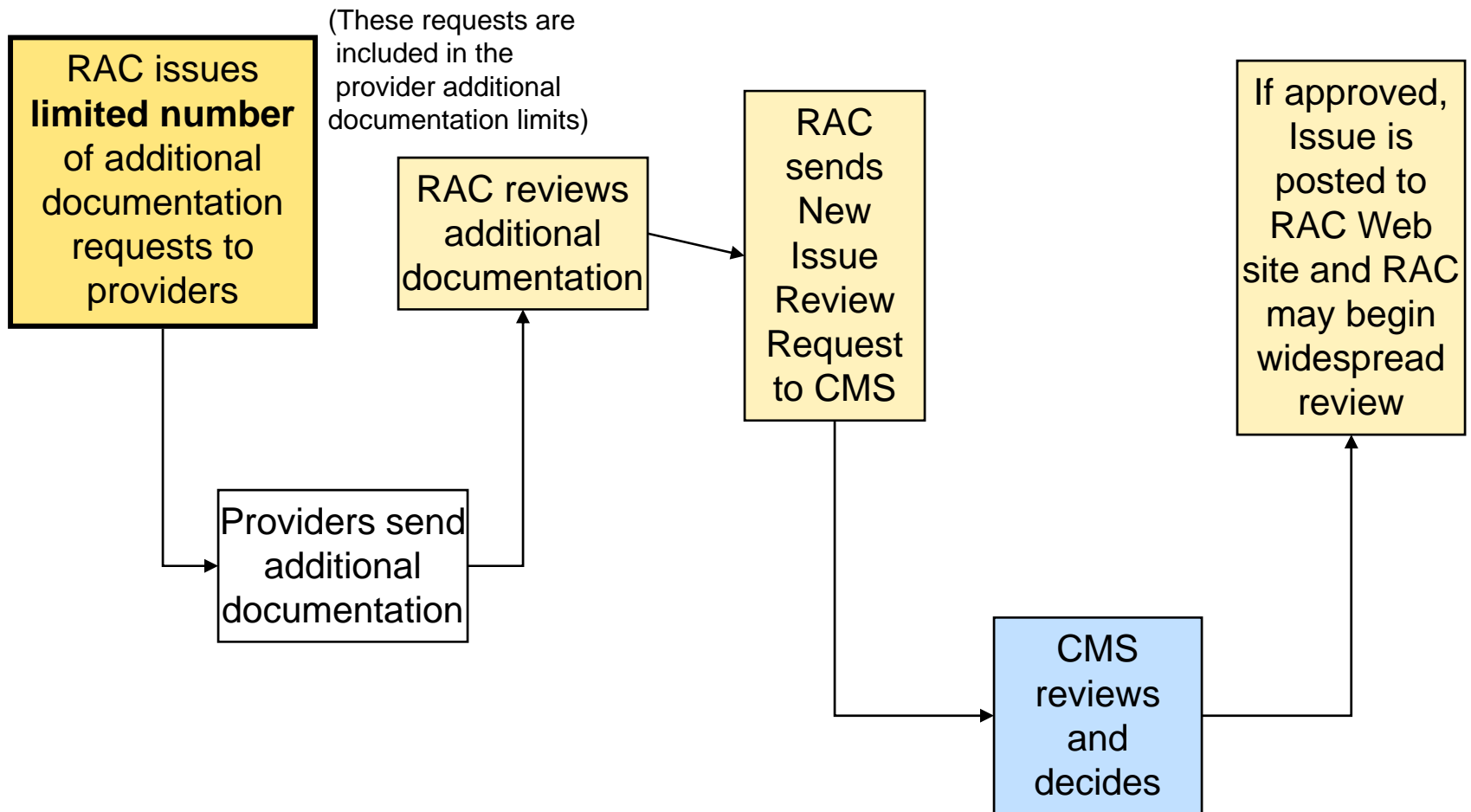
Maximize Transparency

- **New issues are posted to the Web**
- **Major Findings are posted to the Web**
- **RAC claim status Web site (2010)**
- **Detailed review results letter following all complex reviews**

New Issue Review Process for AUTOMATED



New Issue Review Process for COMPLEX



What can providers do to get ready?

Know Where Previous Improper Payments Have Been Found

- **Look to see what improper payments were found by the RACs:**
 - Demonstration findings: www.cms.hhs.gov/rac
 - Permanent RAC findings: will be listed on the RACs' Web sites
- **Look to see what improper payments have been found in OIG and CERT reports**
 - OIG reports: www.oig.hhs.gov/reports.asp
 - CERT reports: www.cms.hhs.gov/cert

Know If You Are Submitting Claims With Improper Payments

- **Conduct an internal assessment to identify if you are in compliance with Medicare rules**
- **Identify corrective actions to implement for compliance**

Prepare to Respond to RAC Additional Documentation Requests

- **Tell your RAC the precise address and contact person they should use when sending additional documentation request letters**
 - Call RAC
 - No later 1/1/2010: use RAC Web sites
- **When necessary, check on the status of your additional documentation (Did the RAC receive it?)**
 - Call RAC
 - No later 1/1/2010: use RAC Web sites

Appeal When Necessary

- The appeal process for RAC denials **is the same** as the appeal process for Carrier/FI/MAC denials
- Do not confuse the “RAC Discussion Period” with the Appeals process
 - **If you disagree with the RAC determination...**
 - Do not stop with sending a discussion letter
 - File an appeal before the 120th day after the Demand letter

Learn from Your Past Experiences

- **Keep track of denied claims**
- **Look for patterns**
- **Determine what corrective actions you need to take to avoid improper payments**

Contacts

- RAC Web site: www.cms.hhs.gov/RAC
- RAC E-mail: RAC@cms.hhs.gov

Region A RAC Contacts at CMS

Contact Person	E-mail
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