Recovery Audit Contractors (RACs) and Medicare

Agenda

- Discuss RAC Program Background Information
- Identify RAC Processes
- Identify Provider Options
- Explain RAC Program keys to success
- Describe Strategies to Prepare for RAC Audits

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

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 no later than 2010
  - Both Statutes gave CMS the authority to pay the RACs on a contingency fee basis.

What is the Current Status of the Permanent RAC Program?

- Provider outreach has occurred in every state
- All RACs have data
- All states are now eligible for review

CMS RAC Review Strategy

- Automated Review- Black & White Issues (current)
- DRG Validation- complex review (current)
- Complex Review for coding errors (current)
- DME Medical Necessity Reviews – complex review (calendar year 2010)
- Medical Necessity Reviews-complex review (calendar year 2010)

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 additional documentation needed)
  - Complex (additional documentation required)
- RACs will not be able to review claims paid prior to October 1, 2007
  - The maximum look-back period is 3 years
- RACs are required to employ a staff consisting of nurses or therapists, certified coders and a physician CMD

Difference from other Post Payment Reviews

- Demand letter is issued by the RAC
- RAC Discussion Period is outside the normal appeal process
- Issues are approved by CMS prior to widespread review
- Approved issues are posted to RAC websites

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”

    Currently superseded by other remark codes; system fix anticipated in April 2010
- Carrier, FI, MAC recoups by offset unless provider has submitted a check or a valid appeal

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.gov/MLNproducts/downloads/MedicareAppealsProcess.pdf
  - 935 MLN Matters
    - http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf

RAC Program Three Key’s 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

Additional Documentation Limits for FY 2010

- Institutional Providers
  - 1% of Medicare claims submitted for the previous calendar year (2008), divided into eight periods (45 days).
  - Based on TIN and Zip Code
- Professional Services and DMEPOS Suppliers
  - Limits have not yet been established
- Two Caps will exist in FY 2010
  - Through March 2010, the cap will remain at 200 ADRs per 45 days for all providers/suppliers.
  - From April through September 2010, providers/suppliers who bill in excess of 100, 000 claims to Medicare (per TIN) will have a cap of 300 ADRs per 45 days

Additional Documentation Limits for FY 2010

- Examples:
  - Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.
  - Provider B has TIN 123456780 and has two physical locations in ZIP codes 12345 and 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

Additional Documentation Limits for FY 2010 For Institutional Providers

- NOTE:
  - The definition of a campus for RAC documentation request limits differs significantly from the definition in 42 CFR 413.65(a)(2) used to determine eligibility for provider-based billing
  - FY 2010 limits are based on submitted claims, irrespective of paid/denied status and/or individual lines, although interim/final bills and RAPs/final claims shall be considered as a unit.
  - In FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.
  - For more information, please see:

http://www.cms.hhs.gov/RAC/Downloads/DRGvalidationADRlimitforFY2010.pdf

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 website
- Detailed review results letter following all complex reviews

Changes Based on Lessons Learned

	Demonstration RACs	Permanent RACs
Look-back period (from claim payment date to date of medical record request)	4 years	3 years
Maximum look-back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
RAC medical director (CMD)	Not Required	Mandatory
Certified coders	Optional	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Vulnerability reporting	Limited	Mandatory
RAC must pay back the contingency fee if the claim overturned at…	…**first** level of appeal	…**all** levels of appeal
Web-based application that allows providers to customize address and contact information	None	Mandatory by January 1, 2010
External validation process	Not Required	Mandatory

What can providers do to get ready?

- Know where previous improper payments have been found
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC additional documentation requests

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' websites
- 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

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
- When necessary, check on the status of your additional documentation (Did the RAC receive it?)

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

Where are New Issues Posted?

- Region A: Diversified Collection Services (DCS)

www.dcsrac.com (Provider Portal/Issues Under Review)

- Region B: CGI Federal

http://racb.cgi.com (Issues)

- Region C: Connolly Healthcare

www.connollyhealthcare.com/RAC (Approved Issues)

- Region D: HealthDataInsights (HDI)

https://racinfo.healthdatainsights.com (New Issues)

Sample New Issues

- Pharmacy Supply and Dispensing Fees
- Wheelchair Bundling
- Urological Bundling
- Blood Transfusions
- IV-Hydration
- Neulasta (Pegfilgrastim)
- Once in a Lifetime Procedures
- Untimed Codes
- Clinical Social Worker (CSW) Services
- DRG Validation (various)

Example New Issue Posting

Issue Name: Wheelchair Bundling

Description: Bundling guidelines for wheelchair bases and options/accessories indicate certain procedure codes are part of other procedure codes and, as a result, are not separately payable.

Provider Type Affected: DME

Date of Service: 10/01/2007 - Open

States Affected: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

Additional Information: Additional information can be found in the following manuals/publications:

http://www.cms.hhs.gov/mcd/viewarticle_pdf.asp?article_id=20284&article_version=32&contractor_id=140

What about Rebilling?

- Providers can re-bill for Inpatient Part B services (ancillary services) listed in the Benefit Policy Manual: http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf
- Rebilling is allowed if all claims processing and timeliness rules are met: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf

Provider Self Disclosures

- If a self-audit results in improper payments; report it to the claims processing contractor.
- If the claims processing contractor agrees with the audit results, the claims will be excluded from RAC review.

RAC Contact Information

- Region A: Diversified Collection Services (DCS)
  www.dcsrac.com
  info@dcsrac.com
- Region B: CGI Federal
  http://racb.cgi.com
  racb@cgi.com
- Region C: Connolly Healthcare
  www.connollyhealthcare.com/RAC
  RACinfo@connollyhealthcare.com
- Region D: HealthDataInsights (HDI)
  https://racinfo.healthdatainsights.com
  racinfo@emailhdi.com

CMS Contact Information

- CMS RAC Website: www.cms.hhs.gov/RAC
- CMS RAC Email: RAC@cms.hhs.gov

Questions?