The Recovery Audit Program and Medicare
Agenda

- What Is A Recovery Auditor?
- Will The Recovery Auditors Affect Me?
- Why Recovery Auditors?
- What Does A Recovery Auditor Do?
- What Are The Providers’ Options?
- What Can Providers Do To Get Ready?
What Is A Recovery Auditor?

The Recovery Auditors Program Mission

- The Recovery Auditor detect and correct past improper payments so that CMS 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 Recovery Auditors Affect Me?

- Yes, if you bill fee-for-service programs, your claims will be subject to review by the Recovery Auditors.
Why Recovery Auditors?

Recovery Audit Legislation:

- Medicare Modernization Act, Section 306
  Required the three year Recovery Audit demonstration
- Tax Relief and Healthcare Act of 2006, Section 302
  Requires a permanent and nationwide Recovery Audit program by no later than 2010

Both Statutes gave the CMS the authority to pay the Recovery Audits on a contingency fee basis.
What Does A Recovery Auditor Do?

The Recovery Audit Review Process:

- Recovery Auditors review claims on a post-payment basis
- Recovery Auditors use the same Medicare policies as Carriers, FIs and MACs: NCDs, LCDs and the CMS Manuals
- Three types of review:
  - Automated (no medical record needed)
  - Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
  - Complex (medical record required)
- Recovery Audits look back three years from the date the claim was paid
- Recovery Auditors are required to employ a staff consisting of nurses, 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
    o Remark Code N432: Adjustment Based on Recovery Audit
      Carrier/FI/MAC recoups by offset unless provider has submitted a check or a valid appeal.
What Is Different?

- Recovery Auditors will offer an opportunity for the provider to discuss the improper payment determination with the Recovery Auditors (this is outside the normal appeal process)
- Issues reviewed by the Recovery Auditor will be approved by the CMS prior to widespread review
- Approved issues will be posted to a Recovery Audits Website before widespread review
What Are The Providers’ Options?

If you agree with the Recovery Auditor determination:

- Pay by check
- Allow recoupment from future payments
- Request or apply for extended payment plan
- Appeal

Appeal Timeframes


935 MLN Matters

Three Keys to Success

• Minimize Provider Burden
• Ensure Accuracy
• Maximize Transparency
Minimize Provider Burden

- Limit the Recovery Auditors “look back period” to three years
- Recovery Auditors will accept imaged medical records on CD/DVD
Ensure Accuracy

- Each Recovery Audit team employs:
  - Certified coders
  - Nurses
  - Therapists
  - A physician CMD
- The CMS’ New Issue Review Board provides greater oversight
- Recovery Audit Validation Contractor provides annual accuracy scores for each Recovery Audit organization
- If a Recovery Auditor loses at any level of appeal, the Recovery Auditor must return its contingency fee
Maximize Transparency

- New issues are posted to the Web
- Vulnerabilities are posted to the Web
- Recovery Audit claim status Website
- Detailed Review Results Letter following all Complex Reviews
What Can Providers Do?

1. Know Where Previous Improper Payments Have Been Found:
   • Look to see what improper payments were found by the Recovery Auditors:
     o Demonstration findings: [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
   • Look to see what improper payments have been found in OIG and CERT reports:
     OIG reports: [www.oig.hhs.gov/reports.html](http://www.oig.hhs.gov/reports.html)
     CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)
What Can Providers Do?

2. **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 promote compliance
   - Appeal when necessary
   - Learn from past experiences
Prepare To Respond To Recovery Auditors Medical Record Requests

- Tell your Recovery Auditor the precise address and contact person they should use when sending Medical Record Request Letters:
  - Call Recovery Auditor
  - Use Recovery Audit Programs’ Websites
- When necessary, check on the status of your medical record (Did the Recovery Auditor receive it?):
  - Call Recovery Auditor
  - Use Recovery Audit Programs’ Websites
Appeal When Necessary

- The appeal process for Recovery Audit denials is the same as the appeal process for Carrier/FI/MAC denials.
- Do not confuse the “Recovery Audit Programs’ Discussion Period” with the Appeals process.
- If you disagree with the Recovery Auditor’s determination:
  - Do not stop with sending a discussion letter.
  - File an appeal before the 120th day after the Demand letter.
Learn From Past Experiences

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

• Recovery Audit Programs’ Website: www.cms.hhs.gov/RAC
• Recovery Audit Programs’ E-mail: RAC@cms.hhs.gov