Recovery Audit Contractors (RACs) and Medicare

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Agenda

1. What is a RAC?
2. Will the RACs affect me?
3. Why RACs?
4. What does a RAC do?
5. What are the providers’ options?
6. What can providers do to get ready?
What is a RAC?

RAC Program Mission

- The RACs will detect and correct past improper payments so that CMS and the Carriers/FIs/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 are subject to review by the RACs

- If so, When?
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<tr>
<th>Claims Available for Analysis</th>
<th>Provider Outreach</th>
<th>Earliest Correspondence</th>
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<tr>
<td>March 1, 2009</td>
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Why do we have RACs?
Top 8 Federal Programs with Improper Payments (2007)

Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.

Medicare receives over 1.2 billion claims per year.

This equates to:

• 4.5 million claims per work day

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

- **Medicare Modernization Act, Section 306:**
  - required the 3-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 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 FIs, Carriers 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, therapists, certified coders & a physician CMD
The Collection Process

- Same as for Carrier/FI/MAC identified overpayments (except Demand Letter comes from the RAC)
  - Carrier/FI/MAC issue Remittance Advice
    - Remark Code N432: “Adjustment Based on Recovery Audit”
  - RAC issues Demand Letter
  - Carrier/FI/MAC recoups by offset unless provider has submitted a check or provider has submitted 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 RAC will be approved by CMS prior to widespread review
- Approved issues will be posted to a RAC website before widespread review
What are the providers’ options?
If you agree with the RAC’s determination:

1. Pay by check on/before Day 30 (interest is not assessed) & do not appeal
2. Allow recoupment (OP + int) on Day 41 & do not appeal
3. Request or apply for an extended repayment plan (OP+ int) & do not appeal
If you disagree with the RAC’s determination:

1. Pay by check on/before Day 30 (interest is not assessed) & file an appeal by Day 120
2. Allow recoupment (OP + int) on Day 41 & file appeal by Day 120
3. Stop the recoupment by filing an appeal prior to Day 31
4. Request or apply for an extended repayment plan (OP + int) & appeal by Day 120
RAC Program’s Three Keys to Success

1. Minimize Provider Burden
2. Ensure Accuracy
3. 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 (CMS requirements coming soon)
- Limit the number of medical record requests
Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
  - 10% of average monthly Medicare claims (max of 200) per 45 days per NPI

- **Other Part A Billers** (Outpatient Hospital, HH)
  - 1% of average monthly Medicare services (max of 200) per 45 days per NPI

- **Physicians** (including podiatrists and chiropractors)
  - Sole Practitioner: 10 medical records per 45 days per NPI
  - Partnership of 2-5 individuals: 20 medical records per 45 days per NPI
  - Group of 6-15 individuals: 30 medical records per 45 days per NPI
  - Large Group of 16+ individuals: 50 medical records per 45 days per NPI

- **Other Part B Billers** (DME, Lab)
  - 1% of average monthly Medicare services (max 200) per 45 days per NPI
Medical Record Limit Example

Outpatient Hospital

- 360,000 Medicare paid services in 2007
- Divided by 12 = average 30,000 Medicare paid services per month
- \( \times 1\% = 300 \)
- Limit = 200 records/45 days (hit the max)
Each RAC employs:
- A physician medical director
- Certified coders
- Nurses
- Therapists

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
- Vulnerabilities are posted to the web
- RAC claim status website (2010)
- Detailed Review Results Letter following all Complex Reviews
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 RAC findings: [www.cms.hhs.gov/rac](http://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.html](http://www.oig.hhs.gov/reports.html)
  - CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)
Know if you’re submitting claims with improper payments?

- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Identify corrective actions that need to take place for compliance
Prepare to Respond to RAC Medical Record Requests

- Tell your RAC the precise address and contact person they should use when sending Medical Record Request Letters
  - Call RAC
  - ✓ No later than 1/1/2010: use RACs’ websites

- When necessary, check on the status of your medical record (Did the RAC receive it?)
  - Call RAC
  - ✓ No later than 1/1/2010: use RACs’ websites

Who will be in charge of responding to RAC Medical Record requests?

What address will we use?

Who will be in charge of tracking our RAC Medical Record requests?
Appeal When Necessary

- The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC denials.

- Don’t 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 120 day after the Demand Letter

Who will be in charge of deciding whether to appeal a RAC denial?

How will we keep track of what we want to appeal, what we have appealed, what our overturn rate is, etc.? 
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

Who will be in charge of tracking our RAC denials, looking for patterns?

How will we avoid making similar improper payment claims in the future?
Contact Information

RAC@cms.hhs.gov

CMS Website
www.cms.hhs.gov/RAC
CMS Website
www.cms.hhs.gov

- Our website offers a vast amount of information concerning Medicare’s rules & regulations, including:
  - Part D prescription drug benefit compliance, physician self-referral prohibition, Medicare’s coverage policies, billing & coding guidelines, provider enrollment, & Medicare secondary payer.
Physician Self-Referrals

- You may visit our website at: www.cms.hhs.gov/PhysicianSelfReferral/
- Anti-kickback statute & physician self-referral law are two fraud & abuse authorities.
- Violations can result in nonpayment, civil monetary penalties, exclusion from Medicare, or criminal penalties.
CMS is committed to partnering with physicians & providers to ensure that beneficiaries receive all health care services to which they are entitled.

We have developed MLN Matters to give providers access to coverage & payment rules in a brief & accurate format.
CMS has established Internet-based PECOS for physicians, providers & suppliers to enroll, make changes, view enrollment information, or check on status of enrollment applications via the Internet.
Physician Quality Reporting Initiative (PQRI)

- www.cms.hhs.gov/pqri/

- Incentive payments for eligible professionals who satisfactorily report data on quality measures for covered services furnished to beneficiaries.

- In 2009, professionals may receive 2.0% PQRI incentive payment for submitting quality data.
Conclusion

Questions or Concerns

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