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The Basics of RAC Audits

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Agenda

- The CMS RAC Program Overview & Update
- RAC Claim Review Process- the Basics
- RAC Target Areas
- Questions

The CMS Recovery Audit Contractor Program

CMS program collects >$900 million in overpayments

CMS announces the 3-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina, and Arizona collected over $900 million in overpayments and returned nearly $38 million in underpayments to providers.

Source: CMS press release 10/6/08. For more information visit: http://www.cms.hhs.gov/RAC

What is the *Recovery Audit Contractors* (RAC) program?

- RAC was developed to further identify claims processing errors.
- Legislation passed to enhance Medicare's current efforts to correct improper payments.
- MMA 2003, Congress directed DHHS to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program.
- Two Types of RACs
  - Medicare Secondary Payer (MSP) focused
  - Claims focused
- The Tax Relief and Health Care Act of 2006 (TRHCA), requires DHHS to make the RAC program permanent and nationwide by no later than January 1, 2010.
  - On 10/6/08 CMS announced names of new national RACs
  - Implementation will take place on a rolling basis in 3 phases beginning 10/1/08
- The RAC program does not detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit.

Source: *CMS* http://www.cms.hhs.gov/RAC

CMS announces permanent national Claim RACs on 10/6/2008

- Region A: Diversified Collection Services, Inc. of Livermore, CA
  - Initially working in ME, NH, VT, MA, RI, and NY *
- Region B: CGI Technologies and Solutions, Inc. of Fairfax, VA
  - Initially working in MI, IN, and MN *
- Region C: Connolly Consulting Associates, Inc. of Wilton, CT **
  - Initially working in SC, FL, CO, and NM *
- Region D: HealthDataInsights (HDI), Inc. of Las Vegas **
  - Initially working in MT, WY, ND, SD, UT, and AZ *

* Additional states planned to be added to each RAC region in 2009

** Connolly and HDI worked on the initial RAC demonstration project

Source: *CMS* http://www.cms.hhs.gov/RAC

CMS announces RAC contingency fee % on 10/10/08

- RACs are paid a contingency fee payment based on the amount of the improper payments they correct for both overpayments and underpayments.

- Each RAC's contingency fee is established during contract negotiations with CMS and thus varies for each RAC.
  - Region A: 12.45%
  - Region B: 12.50%
  - Region C: 9.00%
  - Region D: 9.49%

Source: *CMS* http://www.cms.hhs.gov/RAC

RAC validation contractor (RVC) hired 10/9/08

- CMS announced it hired Provider Resources, Inc. of Erie, PA as the RVC

- Independent third party review entity to work with CMS to provide additional oversight and ensure the RACs are making accurate claim determinations in the permanent program.

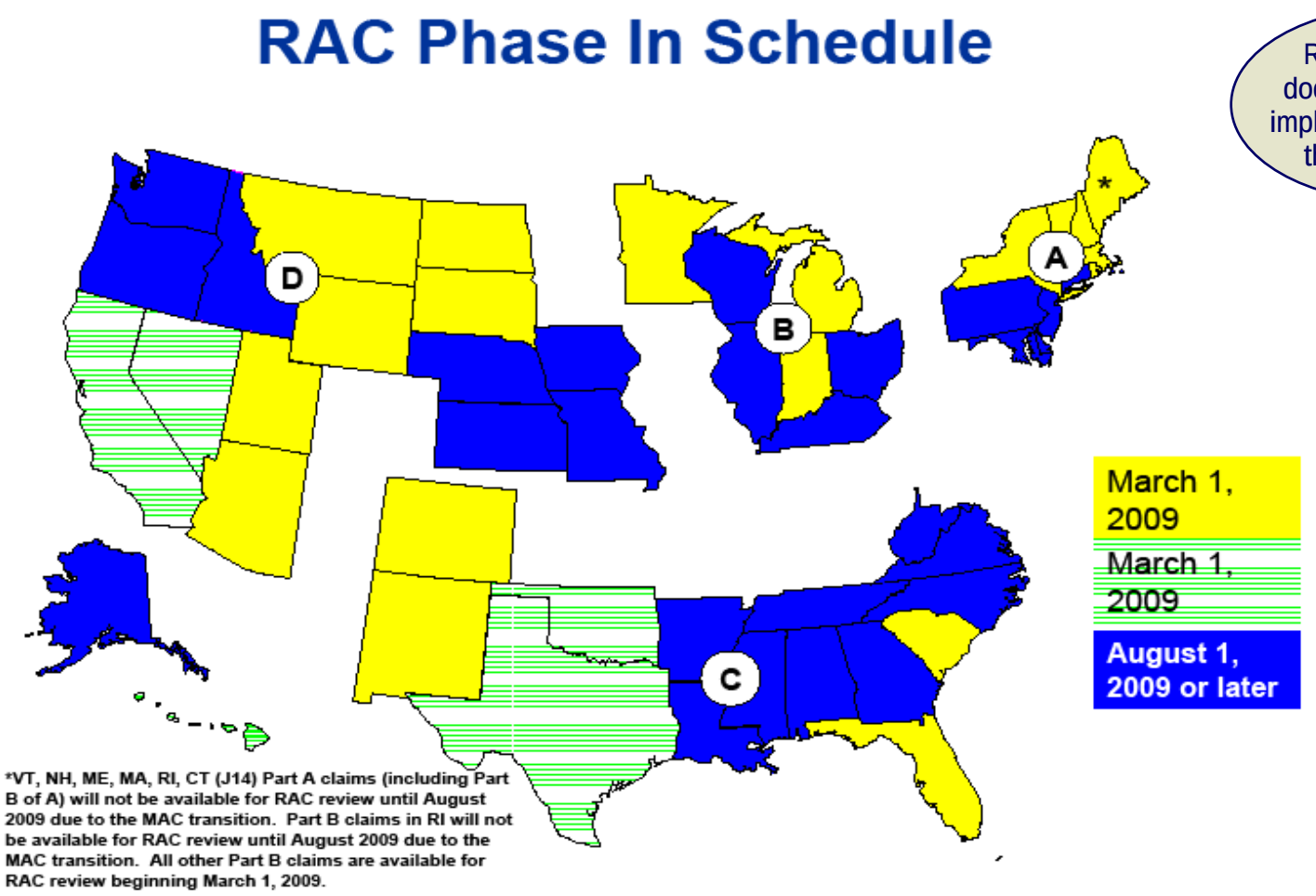
- The RVC will have two tasks:
  - Approve new issues the RACs want to pursue for improper payments
  - Perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments.

Source: C*MS* http://www.cms.hhs.gov/RAC

Program delayed to settle bidder dispute

- Two RAC bidders that were not awarded the contract protested
- Government Accounting Office (GAO) required to suspend the program in November until review of bid process completed
- On February 4, 2009 the parties involved in the protest of the award of the Recovery Audit Contractor (RAC) contracts settled the protests. The settlement means that the stop work order has been lifted and CMS will now continue with the implementation of the RAC program.
  - Under the program, the four RACs will contract with subcontractors to supplement their efforts.
  - PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D.
  - Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C.
  - Each subcontractor has negotiated different responsibilities in each region, including some claim review.

Revised RAC permanent expansion schedule



Revised schedule does not delay the implementation date for the "green" states

Source: http://www.cms.hhs.gov/RAC

Providers included in the RAC Program

Demonstration Program

- Provider types targeted
  - Inpatient Rehabilitation Facilities
  - Hospitals
  - Physicians
  - Skilled nursing facilities
  - Durable medical equipment suppliers
  - Laboratories, Ambulance, Other

Permanent Program

- Provider types targeted
  - Inpatient Rehabilitation Facilities
  - Hospitals
  - Physicians
  - Skilled nursing facilities
  - Durable medical equipment suppliers
  - Laboratories, Ambulance, Other
  - Home Health Agencies
  - Hospices

RAC Audit Process Basics

RAC Claims Audit Process Overview

- Claims Audit Process Phases
  I. Data Screening & Claim Selection
  II. Medical Record Request
  III. Record Review and Status Determination
  IV. Post Review Notification
  V. Overpayment Recoupment
  VI. Post Determination- Other Provider Options and Data Tracking

RAC Claims Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
I. Data Screening & Claim Selection	**Limitations on RAC claim selections**	•RAC may not review the same claim under review by another Medicare contractor, PSC, MAC or law enforcement agency. •RAC Data Warehouse used by the RAC to identify excluded claims which another entity already has the provider and/or claim under review. •Post payment claims review process utilized; "targeted review" approach. •May not target a claim solely because it is a high dollar claim
	Variances in automated review and complex review	**Automated Review- Data Mining** •Proprietary software algorithms to identify improper payments detectable without a medical record review; – Certainty that the service is not covered or is incorrectly coded – No manual/ human reviewer intervention required – Focused on coding and coverage (medical necessity) determinations – Must be supported by a written Medicare policy, article or sanctioned coding guideline exists **Complex Review- Suspect claims with high probability of improper payment, "good cause"** – Random sampling to identify cases non-allowable. – High probability but that service is not covered however not certain – No Medicare policy, article or sanctioned coding guideline exists – Manual review of medical record required to validate improper payment error

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

Automated review

Detects clearly improper Payments (overpayment or underpayment determination) without evaluating the medical record associated with the claim.

- Example 1: Use information systems to find two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. (Medicare claims editor systems can identify these prior to billing.)
- Example 2:

Example of an "Excessive Units" Automated Review Audit

Date of Service	Procedure	Units	Amount Paid
3/1/04	47562 (Cholecystectomy)	3	$2,461.23

CLAIM FACTS

- *Procedure code 47562 is billed and paid with 3 units of service*
- *Same date of service, same beneficiary for all 3*
- *Units should never exceed 1 for a single date of service*
- *Overpayment amount: $1,221*
- *Error Type: Medical Necessity*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims for multiple units of service*
- *Medicare can add edits to the claims processing systems to disallow these "medically unbelievable" situations*

Source: the Florida RAC

Source: CMS http://www.cms.hhs.gov/RAC

Complex review

Detects Likely Improper Payments (overpayment or underpayments) after review of the medical record.

Example 1: Review the medical record to check if the diagnosis code listed on the claim matches the diagnosis described in the medical record

Example 2: Review the medical record to see if the beneficiary's condition meets the Medicare medical necessity criteria for the setting where the service was rendered. (A beneficiary presents to the emergency room with shortness of breath that can be safely and effectively treated in an outpatient setting, but the hospital admits the patient as an inpatient.)

Example of a "Wrong Setting" Complex Review Audit

CLAIM FACTS

- *The beneficiary presents to the emergency room with shortness of breath. EKG is normal. Chest x-ray rules out pneumonia.*
- *The hospital admits the beneficiary for a one-day hospital stay.*
- *Medical record reviews indicates no reason why the services could not have been performed on an outpatient basis.*
- *The entire inpatient claim is denied.*
- *Error Type: Medically Unnecessary*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims for one-day stays to ensure that the services rendered were medically necessary in that setting.*
- *Medicare claims processing contractors can remind hospitals to be careful when admitting patients for one-day stays to make sure that the setting is medically necessary.*

Source: *CMS* http://www.cms.hhs.gov/RAC

RAC Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
II. Medical Record Request	**Provider address customization option** **Limits on the number of records that can be requested**	•RACs must develop a mechanism to allow providers to customize their address and point of contact to which medical request letters are sent. •Each medical record request must inform the provider about the existence of the address customization system **Automated Review- None** **Complex Review** •Provider has 45 days to respond to a request •Record volume requested must be within CMS SOW guideline −Hospitals , Inpatient Rehab Facilities, SNFs, Hospice • 10% of average monthly Medicare claim volume up to a maximum of 200 claims/ 45 days − Other Part A Billers (Outpatient Hospital, Home Health) • 1% of average monthly Medicare services (max of 200) per 45 days −Physicians • Solo Practitioner: 10 records/45 days • Partnership of 2-5 MDs: 20 records/45 days • Group of 6-15 MDs: 30 records/45 days • Large Group MDs (16+): 50 records/45 days − Other Part B Billers (DME, Lab) • 1% of average monthly Medicare services per 45 days •Medical record request limit may not be superceded by bunching record requests − Allowable 50 record sample size of medical records for January and February, cannot be requested as part of a 150 record request in March.

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

RAC Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
II. Medical Record Request	**RACs must pay for record copy production and postage**	•Only required to pay for copies of medical records associated with acute care inpatient prospective payment system (IPPS) hospital DRG claims and long-term care hospital (LTCH) claims. •Medical records photocopying costs reimbursed at rate of – PPS provider records $.12 per page plus first class postage – Non-PPS institutions and practitioner records,$.15 per page – Dialysis /capitated facilities receive $.12 per page plus first class postage – Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement.
	Missed Record Response Date = Default Denial	•RAC may find the claim to be an overpayment if medical records are requested and not received within 45 days. Prior to denying the claim for failure to submit documentation the RACs shall initiate one additional contact before issuing a denial
	Mandated internal review guidelines for RACs	• RACs must develop detailed written review guidelines., a.k.a. “Internal Guidelines." – Allow the RAC to personalize carrier and intermediary LCDs and NCDs. – Specify what information should be reviewed by reviewers and the appropriate resulting determination. – Must make their Internal Guidelines available to CMS upon request. – Internal Guidelines shall not create or change CMS policy.

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

RAC Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
III. Review Records & Determine Status	**Claim review process and criteria application**	**•Individual claim determinations** – RAC must utilize appropriate medical literature and apply appropriate clinical judgment; consider the broad range of available evidence and evaluate its quality before making individual claim determinations. – The extent and quality of supporting evidence is key to defending challenges – Coverage/medical necessity determinations are to be made by RNs or therapists and that coding determinations are made by certified coders – RACs must ensure that their Clinical Medical Director (CMD) is actively involved in examining all evidence used ;acting as a resource to all reviewers
	Types of RAC Determinations	**A. Coverage Determinations-**full or partial overpayment if not covered (i.e., it fails to meet one or more of the conditions for coverage). In order to be covered by Medicare, a service must: −Be included in one of the benefit categories in Title XVIII of Act; −Not be excluded from coverage on grounds other than 1862(a)(1); and −Be reasonable and necessary under Section 1862(a)(1) of the Act •Safe and effective; •Not experimental or investigational •Appropriate duration and frequency •Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member – Furnished in appropriate setting – Ordered and furnished by qualified personnel; – Meets, but does not exceed patient's medical need – At least as beneficial other medically appropriate alternative. •Exceptions – Pneumococcal, influenza and hepatitis B vaccines – Hospice care for palliation/management of terminal illness; – Screening mammography within frequency limits/quality standards; – Screening pap smears and pelvic exams within frequency limits; – Prostate cancer screening tests within frequency limits; – Colorectal cancer screening tests within frequency limits; – One pair of eyeglasses or contact lenses furnished post cataract surgery with interlobular lens insertion

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RAC Audit Process Overview

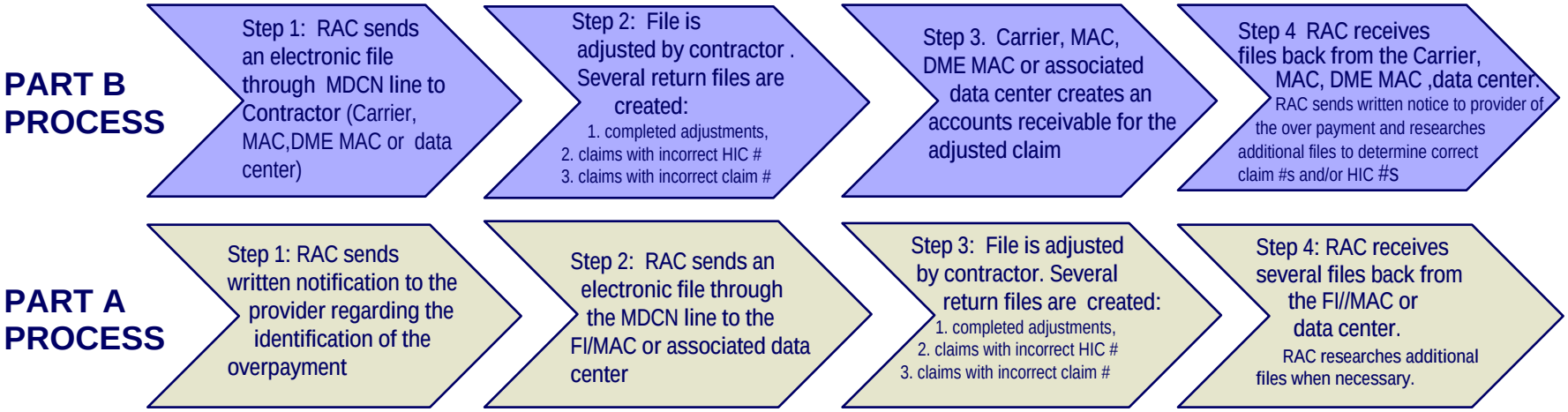
Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
III. Review Records & Determine Status	**Types of RAC Determinations**	**B. Coding Determinations** − Overpayment or underpayment exists if the service is not correctly coded (i.e., it fails to meet one or more of the coding requirements listed in an NCD, local coding article, Coding Clinic, CPT or CPT Assistant.) **C. Other Determinations** − Overpayment or underpayment exists if the claim was •Paid twice (i.e., a "duplicate claim"), •Priced incorrectly, •Claims processing contractor did not apply a payment policy (e.g., paying the second surgery at 50% of the fee schedule amount).
	Full vs. Partial Denials	•**Full denials-** The overpayment amount is the total paid amount for the service in question. A full denial occurs when the RAC determines that: −Submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or −No service was provided. •**Partial denials-** The overpayment amount is not the total amount of the paid claim. −The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary, or −The submitted service was up-coded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made. −The affiliated contractor (AC)failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

RAC Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
III. Review Records & Determine Status	**Determination of overpayment amount**	•In order to determine the actual overpayment amount, the claim adjustment will have to be completed by the AC. •Once the AC completes the claim adjustment, the AC will notify the RAC through the RAC Data Warehouse (or another method instructed by CMS) of the overpayment amount. •RAC must then proceed with recovery. •RACs may only collect the difference between the paid amount and the amount that should have been paid. •RACs will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount.
	Claim Adjustment Process	•When partial adjustments to claims are necessary, the FI/Carrier/MAC/DME MAC will down code the claim whenever possible. Some examples include : −DRG validations where a lower-weighted DRG is assigned with a lower payment amount due −APC claim adjustments resulting in a lower weighted APCs and lower payment amounts −Inpatient stays that should have been billed as outpatient cases

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

Claims Adjustment Process



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RAC Audit Process Overview

Process Phases	Factors to Consider	CMS Statement of Work Guidelines/ Work Steps
IV. Post Review Provider Notification	**Rationale for Denial Determination**	•RACs must document the rationale for the determination. − Rationale must list the review findings including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in improper payment.
	Limits on number of letters reporting errors/ overpayments	•RACs may send the provider only one review results per claim. − May however send one notification letter that contains a list of all the claims denied for the same reason (i.e. all claims denied because the wrong number of units were billed for a particular drug). − In situations in which the RAC identifies two different reasons for a denial, a letter should be sent for each reason identified. The RAC should send two separate letters. The first letter should list all claims in which an improper payment was identified that contained for example a wrong procedure code and the second letter should identify list of claims denied for a wrong diagnosis. •RACs do not need to communicate results of automated reviews that do not result in an overpayment determination. •RACs must communicate the results of every complex review (i.e., where a medical record was obtained), including cases where no improper payment was identified.
	Additional provider rights communication	• Notification letters must include −An explanation of the provider's or supplier's **right to submit a rebuttal** statement prior to recoupment of any overpayment (see PIM Chapter 3, Section 3.6.6); −An explanation of the **procedures for recovery of overpayments** including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the **provider's right to request an extended repayment schedule** −Provider **appeal rights** information; • All demand letter requirements listed in Task 4, Section A- Written Notification to Provider. •Must record the date and format of communication / letter in the RAC Data Warehouse.

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

RAC Audit Process Overview

Process Phases	Factors to Consider	
Post Review Provider Notification/ Demand Letters	**Claim Adjustments not made by RACs**	•After identification and validation of the overpayment and any claim adjustments are made by the MAC, DME MAC and accounts receivable is created. •The RAC may then issue a demand letter to the provider.
	RAC response time limits	•RACs must send a letter to the provider indicating the results of the review **within 60 days** of the exit conference (for provider site reviews) or receipt of medical records unless the CMS Project Officer grants an extension. – May request a waiver from CMS if an extended timeframe is needed; if granted RACs must notify the provider in writing or via a web-based application of the situation resulting in the delay indicate that the Notification of Findings will be sent once CMS approves RAC moving forward with the review.
V. Overpayment Recoupment	**Automatic recoupment timeframe impacted by timing of appeal request**	•Medicare utilizes recoupment, as defined in 42 CFR 405.370 to recover a large percentage of all Medicare provider overpayments. –"Recoupment" as defined in 42 CFR 405.370 is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to the indebtedness. –Overpayments identified and demanded by the RAC will also be subject to the existing withholding procedures. The existing withholding procedures can be found in the Medicare Financial Management Manual, Chapter 4, section 40.1. –Once payments are withheld, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are withheld they are applied against the oldest outstanding overpayment.
	Interest accrual on deferred recoupment	–All payments are first applied to interest and then to principal. –Interest accrues from the date of the demand letter and in accordance with 42 CFR 405.378..
	Repayment installment plans	•Providers ability to repay the overpayment through an installment plan. •RACs have the ability to approve installment plans up to 12 months in length. •Installment plans of greater than 12 -36 months will be forwarded by the RAC to the CMS regional or Central Office for approval.

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

RAC Audit Process Overview

Process Phases	Factors to Consider	
VI. Post Determination – Other Provider Options and Data Tracking		
Provider Rebuttal Opportunity	**Rebuttal discussion prior to appeal process**	• Providers may refute an overpayment determination in two ways: an informal rebuttal process or a formal appeal process • Rebuttal is Informal opportunity to work with RAC to dispute alleged overpayment finding. −Provider must submit a rebuttal statement within 15 days of receiving notice of recoupment of an overpayment. −RAC considers the rebuttal statement and other relevant evidence in determining whether the decision is justified. −Filing a rebuttal statement is optional; not a prerequisite to the appeals process.
Appeal Process	**Five levels of Appeal available to a provider**	• **FIRST LEVEL OF APPEAL:** REDETERMINATION • **SECOND LEVEL OF APPEAL:** RECONSIDERATION • **THIRD LEVEL OF APPEA**L: ADMINISTRATIVE LAW JUDGE • **FOURTH LEVE**L: MEDICARE APPEALS COUNCIL (“MAC”) • **FIFTH LEVEL**: FEDERAL DISTRICT COURT
RAC Warehouse Data Maintenance	**Tracking of provider notification letters/ communications**	• Must update the RAC Data Warehouse with: −Improper payment amount for each claim in question; −Line level claim detail; −Date of the original demand/notification letter; −Appeal status; −Collection detail and/or adjustments due to errors/appeals; −Any other claim level information found in the RAC Data Warehouse User Guide

Process Data Source: CMS Statement of Work for the Recovery Audit Contractor program 2J-1RAC11-5

RAC Target Areas

RAC Focus Areas

- Demonstration program
  - Lack of medical necessity
    - Benefit category denial
      - Services that do not meet benefit criteria for consideration as a covered service
      - 3 day hospital stay prior to SNF admission
    - Statutory exclusion denial
      - Services that are excluded (never covered) by statute under section 1862(a)(1) of the Social Security Act.
    - “Not reasonable and necessary” denial
      - Inappropriate inpatient admissions (acute and rehab) for services that could have been appropriately rendered in another lower level of care/ setting
  - Incorrectly coded services
    - Claim fails to meet one or more of the coding requirements listed in an national coverage decision (NCD), local contractor coding article, Coding Clinic, CPT or CPT Assistant publication.

RAC Focus Areas

- Demonstration program (cont'd)
  - Incorrect payment amounts
    - Contractor payment errors
    - Lack of multiple procedure payment discounting policy application
  - Duplicate/ Medically Unlikely services
    - Multiple, same day invasive/diagnostic procedures
    - Gender, age, other improbable services
- Permanent RAC Program Claim review focuses
  - Will cover the same four categories of issues responsible for improper payments.
  - Changes in specific types of new improper payment claims under consideration have not been announced.
  - RACs must receive approval for new claims focus areas/ issues. to be screened by the RAC validation contractor.

How can facilities prepare for and monitor RAC/Medicare contractor activities?

Utilize Available Methods of Gathering Information from CMS and Medicare Contractors

Although some of the RAC-identified improper payments were due to claims processing errors, the majority of the improper payments were **due to providers billing for services that were incorrectly coded or did not meet Medicare's medical necessity policies**. Provider education about RAC-identified problem areas is a critical component of CMS' strategy to prevent future improper payments.

Review CMS and Medicare Contractor website and newsletter publications for clues on what the next coding error and medical necessity focuses will be.

http://www.cms.hhs.gov/RAC

Source: *CMS* http://www.cms.hhs.gov/RAC

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