



# Recovery Audit Contractor (RAC) Program Basics, What They Must, Can and Cannot Do

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# Agenda

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## **I. RAC Program Update**

- RAC Implementation Timeline
- Provider Outreach and CMS Approved Issues to Date

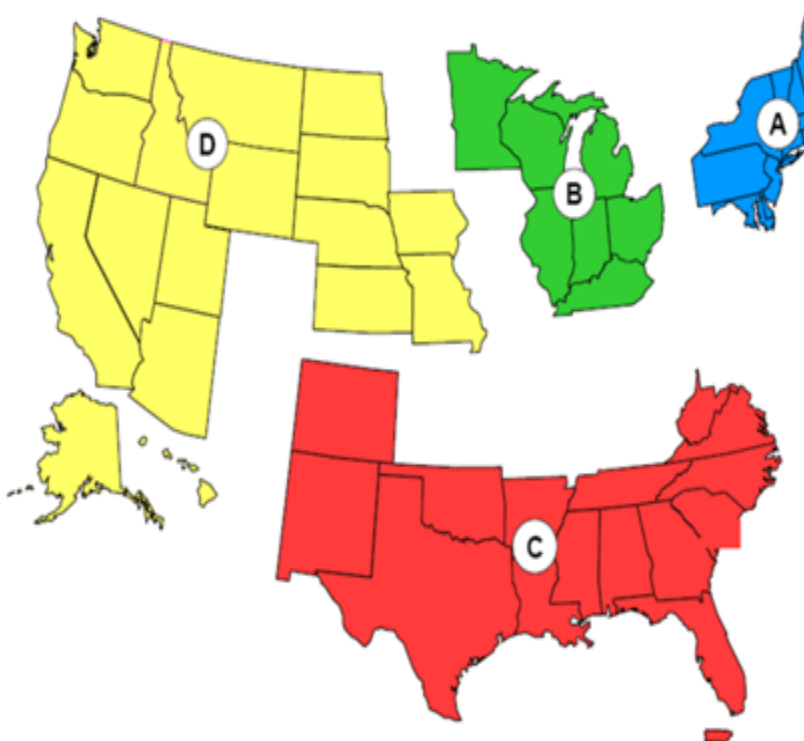
## **II. RAC Program, Basic Guidelines- What RACs Must, Can and Cannot Do**

- Scope
- Approach
- Key Audit Related Activities/ RAC work steps:
  - Provider Selection/ Notifications
  - Data Requests/ Access
  - CMS Statement of Work (SOW) Guidelines and Review Parameters
  - Communication of RAC Audit Results and Recoupment Activities
  - Recoupment/ Repayment Process
  - RAC Participation in the Pre-Appeal/ Appeal Process
  - What's Next?

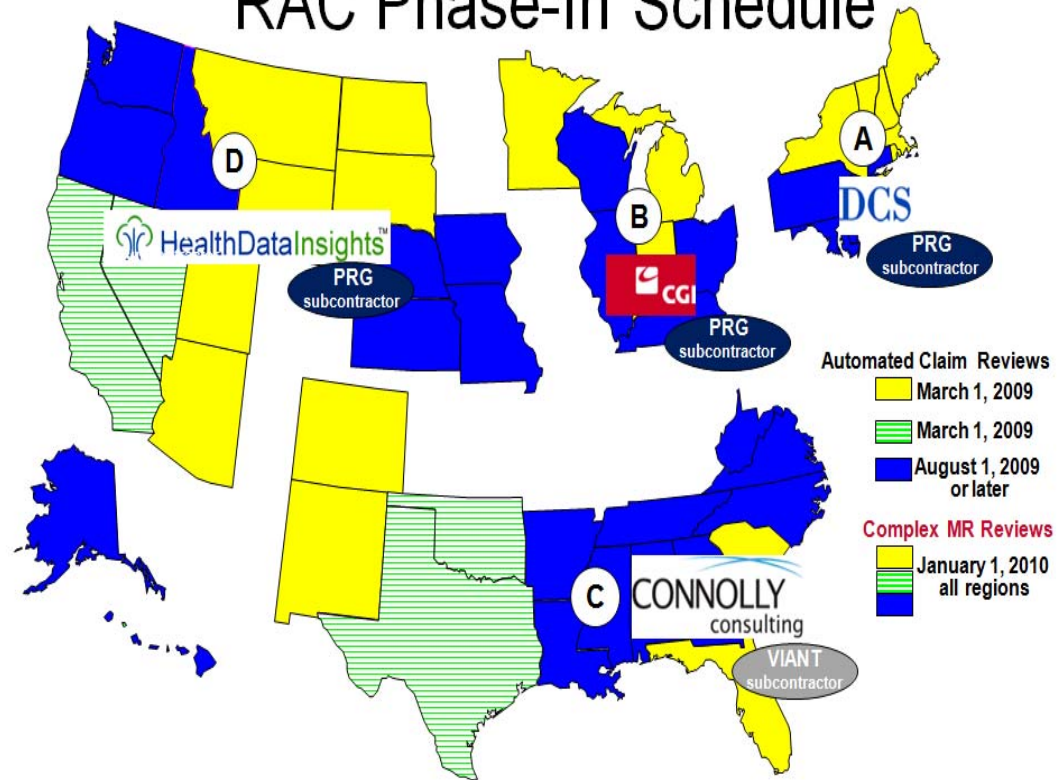
# RAC Implementation Timeline

After a year of the demonstration, Congress required CMS to expand the RAC program to all states by January 1, 2010. Contractors were announced in October 2008, and an ensuing bid protest, which temporarily put the national rollout on hold, was resolved in February of this year. RAC contractors have begun conducting outreach sessions with providers and the first issues eligible for RAC review have been posted.

## RAC Jurisdictions



## RAC Phase-In Schedule



# When will the RACs complete provider outreach? When will all audit issues approved by CMS?

**DCS**

## Region A

Provider Outreach  
Begins: August 5, 2009  
CMS Conference Call  
Connecticut Hospital  
Association

Provider Outreach  
**Ends: Sept. 24, 2009**  
CMS Conference Call  
Pennsylvania Association of  
Medical Equipment

**Automated Review  
Issues Not  
Posted**

1. No Issues Published as of 9/9/09



## Region B

Provider Outreach  
Begins: July 28, 2009  
Conference Call  
Mayo Clinic

Provider Outreach  
**Ends: Oct. 13, 2009**  
Waukesha, WI  
American Case Management  
Association (ACMA)

**Automated Review  
Issues Posted  
8/14/09**

1. Unit Issue- Blood Transfusion >1u
2. Unit Issue- IV Hydration Tx >1u
3. Unit Issue- Bronchoscopy >1u



## Region C

Provider Outreach  
Begins: August 5, 2009  
Cary North Carolina  
North Carolina Hospital  
Association

Provider Outreach  
**Ends: Nov. 5, 2009**  
Robinsville, MS  
Mississippi Rural Health  
Association

**Automated Review  
Issues Posted  
8/13/09**

1. Unit Issue- Neulasta J2505 6mg >1u
2. Unit Issue- Blood Transfusion >1u
3. Unit Issue- Untimed codes > 1u
4. Unit Issue- IV Hydration Tx >1u
5. Unit Issue- Bronchoscopy >1u
6. Unit Issue- Once in Lifetime Tx >1u
7. Unit Issue- Ped.Code Pt > Age Limit
8. IP Clinical Social Worker Svcs
9. DME: Wheelchair Option Unbundling
10. DME: Urological Supply Unbundling



## Region D

Provider Outreach  
Begins: August 10, 2009  
St. Louis, MO.  
Missouri Medical Association

Provider Outreach  
**Ends: Sept. 18, 2009**  
Fountain, MT  
Idaho and Montana  
DME Associations

**Automated Review  
Issues Posted  
08/05/09**

1. Unit Issue- Neulasta J2505 6mg >1u
2. Unit Issue- Blood Transfusion >1u
3. Unit Issue- Untimed codes > 1u
4. Unit Issue- IV Hydration Tx >1u
5. Unit Issue- Bronchoscopy >1u
6. Unit Issue- Once in Lifetime Tx >1u
7. Unit Issue- Ped.Code Pt > Age Limit

# Scope of RAC Permanent Program Activities

Scope	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Automated Review</b></p>	<ul style="list-style-type: none"> <li>• <b>Medicare fee-for-service (FFS) claims</b> which contain improper payments, for which payment was made or have been made under part A or B of title XVIII of the Social Security Act.</li> <li>• <b>Includes claims for services/ items from the following Provider types:</b> acute care and rehabilitation hospitals, physicians, skilled nursing facilities, durable medical equipment suppliers, home health agencies, hospices, ambulance providers, laboratories.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>RACs may not review Medicare Part C or D claims.</b></li> <li>• <b>RACs may not review suppressed or excluded claims</b> maintained by CMS in the web-based RAC Data Warehouse. Excluded or suppressed claims are those that are under current review or have been reviewed by Carrier/ Fiscal Intermediary (FI) / Medicare Administrative Contractor (MAC), Program Safeguard Contractor (PSC), law enforcement or other governmental agency.</li> <li>• <b>RACs may not review claims that have been included in a providers' self-disclosure</b>, including those that represent the claim population in which an extrapolated repayment was calculated and accepted by the Carrier/ FI/ MAC/PSC/other agency.</li> </ul>

# Scope of RAC Permanent Program Activities

Scope	What Can RACs Do?	What Can RACs Not Do?
<b>Complex Review</b>	<ul style="list-style-type: none"><li>• Same Medicare Part A and B paid claims with improper payments as per automated claim scope.</li><li>• Same, full range of provider types.</li><li>• <b>High probability that service is not covered however not certain; Manual review of the medical record required</b> to validate improper payment error.</li><li>• No Medicare policy, article or sanctioned coding guideline exists</li></ul>	<ul style="list-style-type: none"><li>• Same Medicare Part C and D claim review prohibition as for automated claims.</li><li>• Same claim suppression and exclusion requirements as per automated claim reviews.</li><li>• Random sampling to identify cases non-allowable: Extrapolation after cases identified allowable- however only in situations where there is a sustained or high level of payment error or documentation that the Carrier/FI/ MAC educational interventions have failed to correct the payment error.</li></ul>

# RAC Approach to Permanent Program Activities

Approach	What Must/ Can RACs Do?	What Can RACs Not Do?
<b>Automated Review</b>	<ul style="list-style-type: none"> <li>• Claims data provided by CMS contractors</li> <li>• <b>Proprietary software algorithms to electronically screen/ identify improper payments detectable <i>without a medical record review</i>;</b> <ul style="list-style-type: none"> <li>– Focused on coding and coverage (medical necessity) determinations</li> <li>– Must be supported by a written Medicare policy, article or sanctioned coding guideline exists</li> <li>– Certainty that the service is not covered; reflects excessive units or is incorrectly coded</li> <li>– Remote/ off-site data analysis</li> </ul> </li> <li>• <b>“Targeted review” approach: specific CMS approved issues</b> e.g., once- in-a-lifetime procedures, excessive unit issues, age/gender procedure mismatches.</li> </ul>	<ul style="list-style-type: none"> <li>• Automated review issues must not require manual/ human reviewer intervention, e.g. clinician/coder to confirm improper payment.</li> <li>• <b>May not target a claim solely because it is a high dollar claim.</b></li> <li>• May not screen claims data for improper payment issues other than the specific issues CMS and the RAC Validation Contractor (RVC) have pre-approved as automated claims review issues.</li> <li>• <b>Random sampling of all services/ claim types to identify cases is non-allowable;</b> RACs may perform random claim selections only for the purpose of conducting extrapolation post improper claim identification.</li> <li>• <b>Additionally RACs cannot use extrapolation unless there is evidence of a sustained or high level of payment error</b> or documented education intervention by the Carrier/FI/MAC/ QIO which failed to correct the payment error.</li> </ul>

# RAC Approach to Permanent Program Activities

Approach	What Can RACs Do?	What Can RACs Not Do?
<b>Complex Review</b>	<ul style="list-style-type: none"><li>• RACs must request and review the medical record to make complex coverage determinations and coding determinations;</li><li>• While not typical, RACs may opt to conduct on-site medical record reviews if Providers agree to onsite approach.</li></ul>	<ul style="list-style-type: none"><li>• RACs may not utilize reviewers other than RNs, therapists, certified coders.</li><li>• RACs must minimally employ a full-time medical director/ MD to be available to provide oversight/ review denied medical necessity claims, e.g. inpatient admission criteria issues. RAC may not employ several part-time equivalent MDs to achieve the minimal 1.0 FTE requirement.</li><li>• RAC nurses and coders may not conduct reviews for a provider who was their employer within the previous 12 month period.</li></ul>



# Data Request/ Access for RAC Permanent Program Activities

Key Activities/ Work Steps	What Can RACs Do?	What Can RACs Not Do?
<b>Data Requests/ Access- Automated Review</b>	<ul style="list-style-type: none"> <li>• <b>RACs receive data through access into the CMS Data Center.</b> Offsite/ remote data analysis.</li> <li>• RACs must utilize the RAC Data Warehouse to identify suppressed/excluded claims.</li> <li>• RACs must develop a mechanism to allow providers to customize their address and point of contact , e.g. RAC Website/ portal options</li> </ul>	<ul style="list-style-type: none"> <li>• RACs must not screen suppressed/excluded claims which another entity already has under review.</li> </ul>
<b>Data Requests/ Access- Complex Review</b>	<ul style="list-style-type: none"> <li>• <b>RACs must request medical records from the provider for complex review types such as for coding accuracy and medical necessity .</b></li> <li>• Evidence of medical necessity defined in national and local coverage decisions (NCDs/LCDs) and Medicare manuals and policies.</li> <li>• Each medical record request must inform the provider about the existence of the address customization system.</li> <li>• RACs may deny a claim if the provider fails to submit the requested supporting documentation within the allotted 45 day period.</li> </ul>	<ul style="list-style-type: none"> <li>• May not request records more frequently than every 45 days: Record volumes requested must not exceed CMS limits per provider type.               <ul style="list-style-type: none"> <li>- Inpatient Hospital, IRF, SNF, Hospice: 10% of average monthly Medicare claims (max of 200) per 45 days .</li> </ul> </li> <li>• Other Part A Billers(Outpatient Hospital, HH) 1% of average monthly Medicare services (maximum of 200) per 45 days               <ul style="list-style-type: none"> <li>- Physicians: Solo Practitioner: 10 records/ 45 days ; 2-5 MD Practice: 20records/45 days; 6-15 MD Group: 30 records/ 45 days; Large Group (16+MDs):50 records/45 days</li> <li>- Other Part B Billers (DME, Lab) :1% of average monthly Medicare services/ 45 days.</li> </ul> </li> </ul>

# Data Request/ Access for RAC Permanent Program Activities

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Data Requests/ Access- Complex Review (Continued)</b></p>	<ul style="list-style-type: none"> <li>• <b>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.</b></li> <li>• Medical records photocopying costs reimbursed at rate of               <ul style="list-style-type: none"> <li>– PPS provider records <b>\$.12 per page</b> plus first class postage</li> <li>– Non-PPS institutions and practitioner records, \$.15 per page</li> <li>– Dialysis/ capitated facilities receive \$.12 per page plus first class postage</li> <li>– Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement.</li> </ul> </li> <li>• <b>RACs may find a claim to be an overpayment if medical records are requested and are not received within 45 days.</b></li> <li>• Prior to denying the claim for failure to submit documentation the RAC must initiate one additional contact before issuing a denial</li> </ul>	<ul style="list-style-type: none"> <li>• RACs may not refuse to pay providers for copies of medical records. Checks to providers must be issued within 45 days of receiving the medical record.</li> </ul>

# CMS Statement of Work (SOW) Guidelines/ Review Parameters for RAC Audit Execution

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Review Parameters/ Audit Execution - Automated and Complex Reviews</b></p>	<ul style="list-style-type: none"> <li>• <b>RACs must develop detailed written review guidelines., a.k.a. “Internal Guidelines.”</b> <ul style="list-style-type: none"> <li>– Allow the RAC to personalize carrier and intermediary LCDs and NCDs.</li> <li>– Must make their Internal Guidelines or algorithms available to CMS upon request.</li> <li>– Internal Guidelines shall not create or change CMS policy.</li> <li>– Specify what information should be reviewed by reviewers and the appropriate resulting determination.</li> </ul> </li> <li>• <b>RACs must make individual claim determinations</b> <ul style="list-style-type: none"> <li>– 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.</li> <li>– The extent and quality of supporting evidence is key to defending challenges</li> <li>– RAC Clinical Medical Director s(CMD) must be actively involved in examining evidence used ;acting as a resource to other reviewers</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>RAC may not review or reopen a claim if it has been more than 3 years from the claim’s initial determination date or claim paid date (“look back period”) and/or prior to 10/1/2007.</b></li> <li>• <b>RAC CMDs are not required to review every denied claim/ case;</b> intent however is that CMDs will be available to assist in provider rebuttal or discussion periods as indicated as well as in the reconsideration / appeals process.</li> </ul>

# CMS Statement of Work (SOW) Guidelines/ Review Parameters for RAC Audit Execution

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Review Parameters/ Audit Execution</b></p> <p><b>Automated and Complex Reviews</b></p>	<p><b>A. RACs must make Coverage Determinations- full or partial overpayment if not covered</b> (i.e., claim fails to meet one or more of the conditions for coverage ). In order to be covered by Medicare, a service must:</p> <ul style="list-style-type: none"> <li>- Be included in one of the benefit categories in Title XVIII of Act;</li> <li>- Not be excluded from coverage on grounds other than 1862(a)(1); and</li> <li>- Be reasonable and necessary under Section 1862(a)(1) of the Act</li> </ul> <ul style="list-style-type: none"> <li>• Safe and effective;</li> <li>• Not experimental or investigational</li> <li>• Appropriate duration and frequency</li> <li>• 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               <ul style="list-style-type: none"> <li>- Furnished in appropriate setting</li> <li>- Ordered and furnished by qualified personnel;</li> <li>- Meets, but does not exceed patient's medical need</li> <li>- At least as beneficial other medically appropriate alternative.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>RACs may not make a coverage denial without explaining rationale and referencing applicable Medicare policies to support the denial.</b></li> </ul>

# CMS Statement of Work (SOW) Guidelines/ Review Parameters for RAC Audit Execution

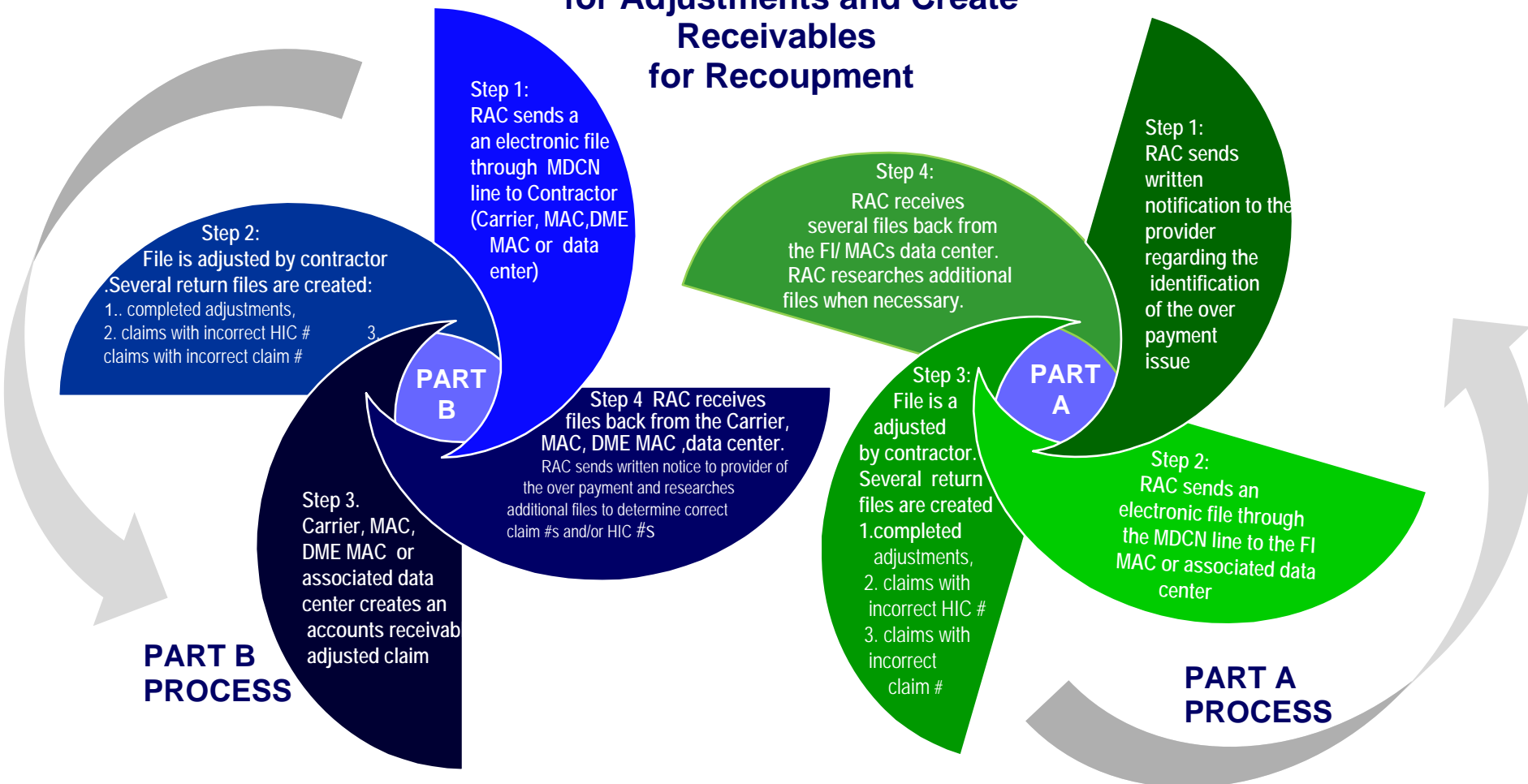
Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p data-bbox="73 354 401 549"><b>Review Parameters/ Audit Execution and Determination Types Automated and Complex Reviews</b></p> <p data-bbox="73 978 280 1013"><b>Denial Types</b></p>	<p data-bbox="459 354 1120 692"><b>B. Make Coding Determinations</b> – Overpayment or underpayment may exist if the diagnosis or service is not correctly coded (i.e., it fails to meet one or more of the coding requirements listed in an national (NCD) or local (LCD) coverage decision, MAC bulletin or coding article, Coding Clinic, CPT manual or CPT Assistant—official coding guidelines)</p> <p data-bbox="459 706 1120 1006"><b>C. Make Other Determinations</b> – Overpayment or underpayment exists if the claim was</p> <ul style="list-style-type: none"> <li>• Paid twice (i.e., a “duplicate claim”),</li> <li>• Priced incorrectly,</li> <li>• Claims processing contractor did not apply a payment policy (e.g., paying the second surgery at 50% of fee schedule )</li> </ul> <p data-bbox="459 1021 1120 1313">• <b>Make Full vs. Partial Denial Decisions</b> – Full denials - The overpayment amount is the total paid amount for the service in question. A full denial occurs when the RAC determines • Submitted service not reasonable and necessary; no other service (for that type of provider) would have been reasonable and necessary, or no service was provided.</p>	<ul style="list-style-type: none"> <li>• <b>RACs cannot make subjective coding determinations</b>, e.g. Evaluation and Management visit code type/ mapping to correct age group yes but not an E&amp;M level determination, e.g. a level two versus a level three visit code.</li> </ul>

# CMS Statement of Work (SOW) Guidelines/ Review Parameters for RAC Audit Execution

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Review Parameters/ Audit Execution and Denial Types</b></p> <p><b>Automated and Complex Reviews</b></p>	<ul style="list-style-type: none"> <li>• <b>Make Full vs. Partial Denial Decisions</b> <ul style="list-style-type: none"> <li>– <b>Partial denials:</b> The overpayment amount is not the total amount of the paid claim.</li> </ul> </li> <li>• The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary, or</li> <li>• 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.</li> <li>• 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).</li> <li>• <b>RACs must determine the actual overpayment amount;</b> the claim adjustment will have to be completed by the associated contractor (AC).</li> <li>• <b>Once the AC completes the claim adjustment, the AC will notify the RAC</b> through the RAC Data Warehouse (or another method instructed by CMS).</li> <li>• <b>RAC must then proceed with recovery.</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>RACs cannot be paid a full contingency payment on partial denials; only the difference between the original claim paid amount and the revised claim paid amount.</b></li> <li>• When partial adjustments to claims are necessary, the FI/Carrier/MAC/DME MAC will down code the claim whenever possible.</li> </ul>

# Claims Adjustment Process Coordination

## MAC/ FIs Process PART A/ B Claims for Adjustments and Create Receivables for Recoupment



# Communication of RAC Audit Results and Recoupment Requirements

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Result Status Notification and Recoupment Communication-</b></p> <p><b>Automated and Complex Review</b></p>	<ul style="list-style-type: none"> <li>• RACs may send providers routine, form letters that have been approved by the CMS Project Officer.</li> <li>• RACs must document the rationale for the determination.</li> </ul> <p>–Rationale must list the review findings including a <u>detailed description of the Medicare policy or rule that was violated</u> and a <u>statement as to whether the violation resulted in improper payment</u>.</p> <p>–<b>Notification letters* must include:</b></p> <ol style="list-style-type: none"> <li>a) an explanation of the provider’s or supplier’s right to submit a rebuttal statement prior to recoupment of any overpayment* *</li> <li>b) 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,</li> <li>c) the provider’s right to request an extended repayment schedule and</li> <li>d) the provider appeal rights information;</li> </ol> <ul style="list-style-type: none"> <li>• RACs must record the date and format of communication / letter in the Data Warehouse</li> </ul>	<ul style="list-style-type: none"> <li>• RACs cannot fail to communicate the results of each complex review (i.e., where a medical record was obtained), including cases where no improper payment was identified.</li> </ul> <p>•RACs may not send the provider more than one review result per claim.</p> <p>•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.</p> <p>•RACs cannot rely on the FI/Carrier/MAC to solely identify all of its recouped overpayments</p> <p>•RACs cannot be paid more than the contingency fee due</p> <ul style="list-style-type: none"> <li>– Region A -12.45%;</li> <li>– Region B - 12.50%;</li> <li>– Region C - 9%;</li> <li>– Region D - 9.49%</li> </ul>



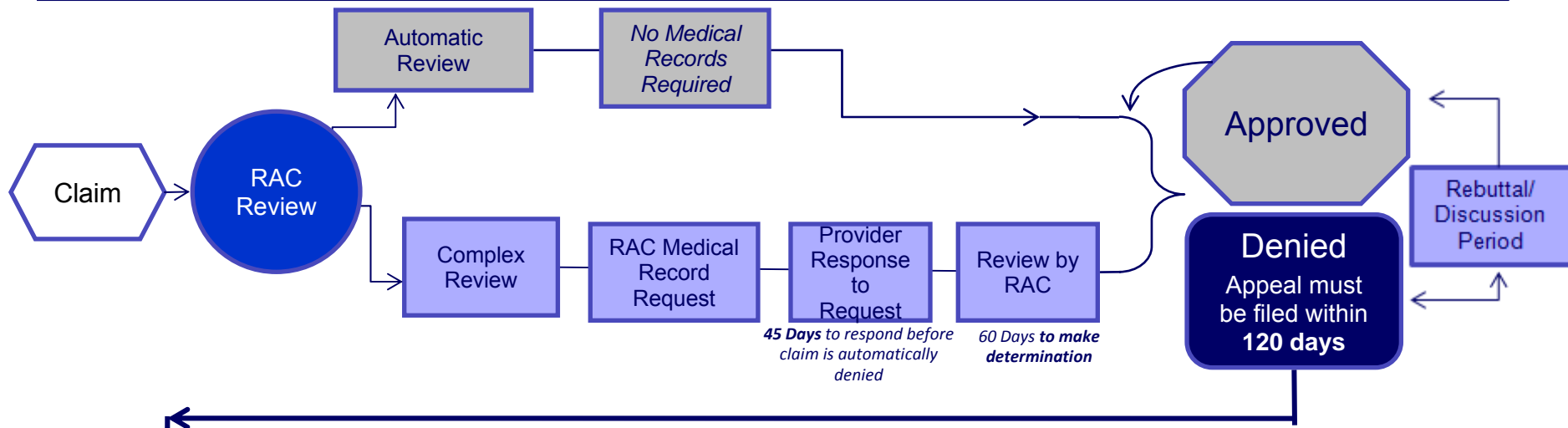
# Communication of RAC Audit Results and Recoupment Requirements

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Result Status Notification and Recoupment Communication-</b></p> <p><b>Automated and Complex Review</b></p>	<ul style="list-style-type: none"> <li>• After identification and validation of the overpayment and any claim adjustments are made by the MAC, DME MAC,..etc. an accounts receivable is created.</li> <li>• <b>RACs must then issue a demand letter to the provider.</b></li> <li>• RACs do not need to communicate results of automated reviews that do not result in an overpayment determination.</li> <li>• <b>RACs must request a waiver from CMS if an extended timeframe (&gt;60 days) is needed for review;</b> 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.</li> <li>• <b>By 2010 RACs will be required to post the status of claims reviews/ results</b> such that providers may check the status of their claims on-line. / independently</li> <li>• RACs may send one notification letter that contains a list of all the claims denied for the same reason.</li> </ul>	<ul style="list-style-type: none"> <li>• RACs cannot fail to send a letter to the provider indicating the results of the review <b>within 60 days</b> of the exit conference (for provider site reviews) or from receipt of medical records unless the CMS Project Officer grants an extension.</li> <li>• RACs cannot fail to communicate the results of each complex review (i.e., where a medical record was obtained), including cases where no improper payment was identified.</li> <li>• RACs may not send the provider more than one review result per claim.</li> <li>• 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.</li> </ul>

# RAC Participation in the Provider Recoupment/ Repayment Process

Key Activities/ Work Steps	What Can RACs Do?	What Can RACs Not Do?
<p><b>Recoupment/ Repayment Process- Automated and Complex Review</b></p>	<ul style="list-style-type: none"> <li>• <b>Medicare utilizes recoupment, as defined in 42 CFR 405.370 to recover a large percentage of all Medicare provider overpayments.</b></li> <li>– “Recoupment” as defined in 42 CFR 405.370 is the recovery by Medicare of an outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to the indebtedness.</li> <li>– Overpayments identified and demanded by the RAC will also be subject to the existing withholding procedures*</li> <li>– 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.</li> <li>– 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..</li> <li>• Providers have ability to repay the overpayment through an installment plan; <b>RACs have the ability to approve installment plans up to 12 months length.</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>RACs cannot approve repayment installment plans of greater than 12 -36 months;</b> Must forwarded to the CMS regional or Central Office for approval.</li> </ul>

# Appeal Process Overview

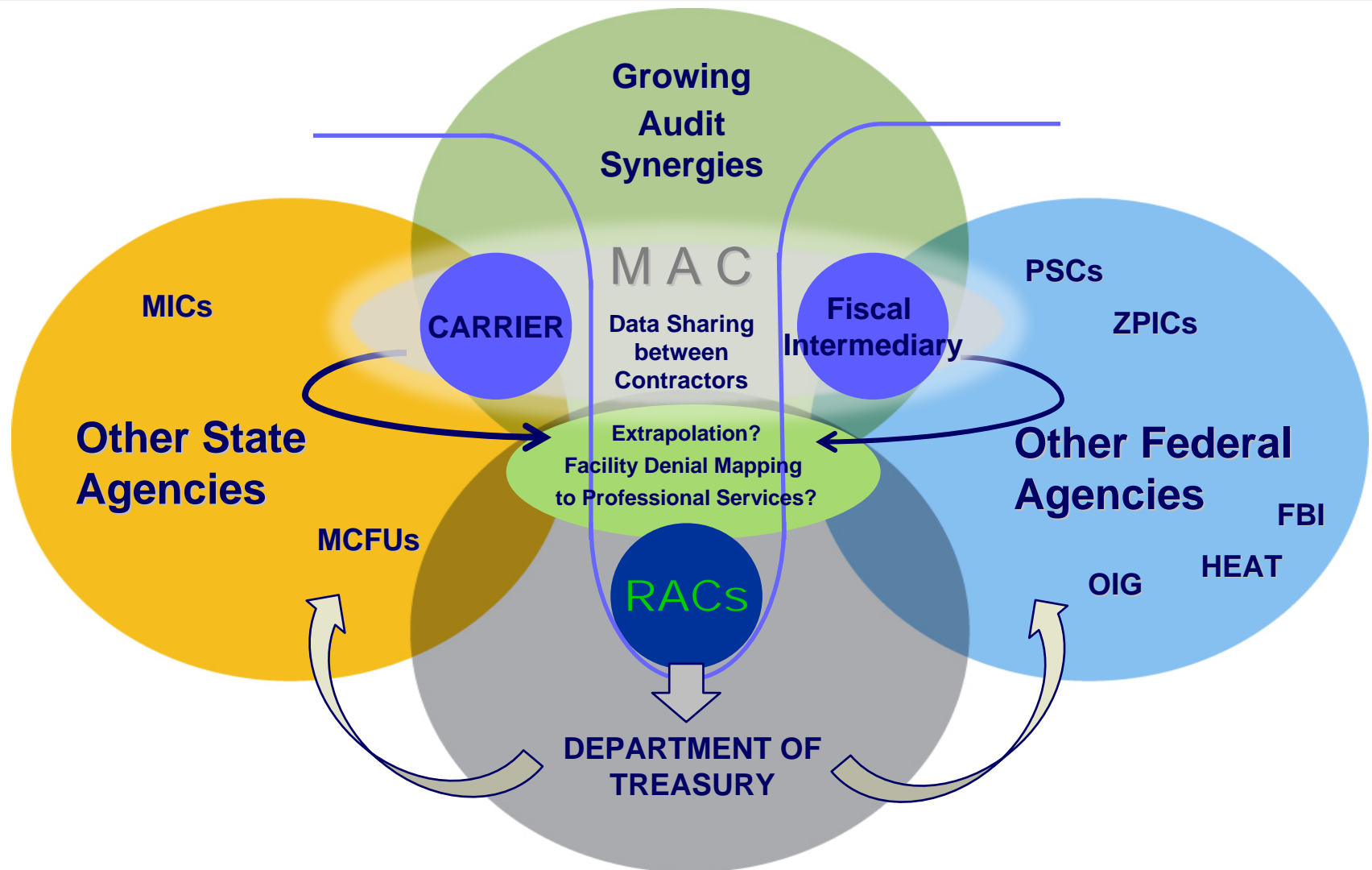


The Centers for Medicare and Medicaid Services, The Medicare Appeals Process, Medicare Learning Network, January 2008

# RAC Participation in Appeal Activities

Key Activities/ Work Steps	What Must/ Can RACs Do?	What Can RACs Not Do?
<p><b>Pre-Appeal and Appeal Process-</b></p> <p><b>Automated and Complex Review</b></p>	<ul style="list-style-type: none"> <li>• <b>RACs must respond to provider request for clarification during the discussion period.</b></li> <li>• <b>Providers may refute an overpayment determination in two ways: 1) Contact the RAC within 15 days of Demand Letter ( Automated) or Results Review Letter (Complex) to initiate discussion period and issue resolution process, AKA the “rebuttal period” (pre-appeal) or 2) Initiate the formal five level appeal process</b></li> <li>• Discussion period is opportunity to work with RAC to dispute the alleged overpayment and provide additional documentation.               <ul style="list-style-type: none"> <li>–With an automated review, the provider finds out there has been a review and a denial when it receives a demand letter from the RAC. Receipt of that letter kicks off the discussion period.</li> <li>–For complex reviews, the discussion period begins when the provider receives the review results letter, which would arrive prior to the demand letter, giving the provider additional time to discuss the denial with its RAC.</li> <li>–The discussion period ends upon recoupment of the money (day 41) regardless of review type.</li> </ul> </li> <li>• <b>The RAC can refer cases to the Department of the Treasury for further action/ investigation</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>RACs cannot refuse to accept additional medical record data during the discussion period;</b> During the redetermination (Level 1 Appeal) or reconsideration period. (Level 2 Appeal) additional, “missing” data may also be accepted. By the third level of Appeal, Administrative Law Judge review, providers may no longer submit additional data for review.</li> <li>• <b>RACs cannot receive payment for denied claims overturned at any level of appeal.</b></li> <li>• <b>RACs cannot fail to update the RAC Data Warehouse with :</b> <ul style="list-style-type: none"> <li>a) improper payment amount for each claim,</li> <li>b) line level claim detail;</li> <li>c) date of the original demand/notification letter;</li> <li>d) appeal status; e) collection detail and/or adjustments due to errors/appeals;</li> <li>e) other claim level information found in the RAC Data Warehouse User Guide</li> </ul> </li> </ul>

# What's Next?





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