MAC Roles and Relationships with the RACs

Deanna Cruser, CGS
Agenda

- RAC Mission
- MAC’s Medical Review
- MAC’s Role in the RAC process
- Demand Letters and Collection Process
- Appeals Process
- Resources
Objective

To provide an understanding of the roles and responsibilities of the Medicare Administrative Contractor (MAC) in the Recovery Audit Contractor (RAC) review process
Did you know?

- Medicare receives over 1.2 Billion claims per year.
- This equates to:
  - 4.5 Million claims per work day
  - 574,000 claims per hour
  - 9,579 claims per minute
Mission of the RAC Program

- RACs are tasked with identifying and correcting improper payments and returning those monies to the Medicare trust fund.
- In addition to recoveries, RACs give CMS a window into areas where additional attention may be needed:
  - Provider education,
  - Pre-payment or post payment edits,
  - Data mining, or
  - Medical record review.
MAC Medical Review

- Conducts Data Analysis, based on:
  - Claims history files
  - Comprehensive Error Rate Testing (CERT) findings
  - Office of the Inspector General (OIG)
  - Centers for Medicare & Medicaid Services (CMS) request
  - Recovery Audit Contractor (RAC) findings
- Develops Error Rate Reduction Plan (ERRP)
MAC's Role in the RAC Process

- Adjust claims, as identified by the RAC
- Issue RAC demand letters (effective January 2012)
  - Notifying RAC when account receivable is created
  - Applying recoupments
- Immediate offset and provider refund collection
- First level of appeal
- Customer service
- Educate on Medicare policy
Demand Letters

As of January 3, 2012, CMS transferred the responsibility for issuing demand letters from the RACs to the MACs.

- Automated overpayment request letters
- Sent to the provider’s master physical address on file with the MAC

The MAC follows the same process it uses to recover any other payment.

Benefits of MACs Issuing RAC Demand Letters

- All overpayment requests are now consolidated at the MAC level
  - Helps to eliminate the confusion of MAC and RAC coordination
  - Consistency with the process of recoupment related to Medicare overpayments
MAC Responsiblities

**MACs will:**

- Establish the Accounts Receivable (AR) and send demand letters following the normal improper payment process
- Include RAC contact information on the demand letters
- Answer provider’s administrative concerns regarding recovery timeframes and appeals, as well as general Medicare coverage guidelines
RAC Responsibilities

RACs will:

- Continue producing Review Results letters for complex reviews
- Answer provider questions/concerns regarding audit outcomes
- Produce review rationale content for automated and semi-automated reviews
Provider Options: If you Agree with Overpayment Decision

- Repay excess funds or allow recoupment
  - Recoupment occurs on Day 41, if arrangements were not already made by provider
  - Handled by the MAC

- Rebuttal
  - Opportunity to prove why the recoupment would cause a “financial hardship”
  - Does not address appeals rights or documentation to support the claim
  - Must be requested within 15 days of decision
  - Handled by the MAC
Provider Options: If You Disagree with Overpayment Decision

- **Discussion Period**
  - Opportunity to provide additional information to indicate why recoupment should not occur
  - Must be requested within 40 days of decision
  - Handled by the RAC

- **Redetermination (First Level Appeal)**
  - Provider disagrees with overpayment decision
  - Submit Redetermination request, along with all appropriate supporting documentation
  - Must be requested within 120 days of decision
  - Handled by the MAC
# Provider Options Chart

## Provider Options - RAC Overpayment Determination

<table>
<thead>
<tr>
<th></th>
<th>Discussion Period</th>
<th>Rebuttal</th>
<th>Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Which option should I use?</strong></td>
<td>The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.</td>
<td>The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)</td>
<td>A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Who do I contact?</strong></th>
<th>Recovery Audit Contractor (RAC)</th>
<th>Claim Processing Contractor</th>
<th>Claim Processing Contractor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timeframe</strong></td>
<td>Day 1 - 40</td>
<td>Day 1-15</td>
<td>Day 1-120</td>
</tr>
<tr>
<td><strong>Timeframe Begins</strong></td>
<td>Automated Review: Upon receipt of Demand Letter</td>
<td>Date of Demand Letter</td>
<td>Upon receipt of Demand Letter</td>
</tr>
<tr>
<td><strong>Timeframe Ends</strong></td>
<td>Day 40 (offset begins on day 41)</td>
<td>Day 15</td>
<td>Day 120</td>
</tr>
</tbody>
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Collection Process

- When claims are adjusted based on a RAC review
  - Medicare Remittance will show Remark Code N432: “Adjustment Based on Recovery Audit”

- Demand letters sent by MAC
  - Discussion period begins
  - Appeals timeline starts

- MAC recoups by offset on Day 41
  - Unless provider has paid in full, or submitted a valid appeal request by Day 30
  - Interest begins to accrue at Day 30
Appeals Process

- The appeals process for RAC denials is the same process for any other Medicare denial.
  - Request must be made in writing.
  - Include a copy of the demand letter.
  - Clearly state that you are requesting a redetermination of the overpayment.
  - Submit all appropriate documentation to support your claim.
- File an appeal to the MAC within 120 days of the date of your demand letter.
- File within 30 days of demand letter to stop recoupment of funds.
- If you disagree with RAC determination, remember to take advantage of RAC discussion period.
Successful Appeals

- Provider is reimbursed for covered items/services.
- Any funds recouped by the MAC and any interest paid (by the provider) will be repaid to provider.
Unsuccessful Appeals

- Provider will be notified via letter from the MAC.
- Letter will contain instructions for pursuing further appeal rights.
  - Reconsideration
  - Administrative Law Judge
  - Appeals Council Review
  - U.S. District Court
Resources

- CMS Website:  [http://www.cms.gov/RAC](http://www.cms.gov/RAC)
  - RAC statement of work
  - Program updates
  - Fact sheets
  - Appeal information
  - RAC contact information
- E-mail:  [RAC@cms.gov](mailto:RAC@cms.gov)
Questions?