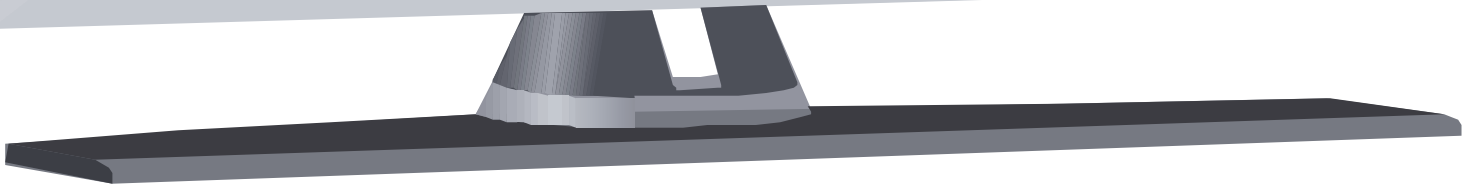
Recovery Audit Contractors (RAC)

Looking for Improper Medicare Payments in All the Right Places

Contents of Presentation



Background Information on RAC

- Congress passed legislation to allow Medicare to use Recovery Audit Contractors (RAC) to identify and correct improper payments.
- Besides recovering money for the Medicare Trust Fund, the findings from these audits will let Medicare know what kinds of claim processing edits and provider education they need to put in place to prevent improper claims from being submitted and paid in the first place.
- At this point, RAC audits only apply to Parts A & B – not Parts C (Medicare Advantage) or D (Drugs) and not Secondary Medicare claims.

What's in it for the RAC?

- RACs are not part of Medicare. They are hired by Medicare to find overpayments.
- RACs are paid a percentage of the overpayment (and underpayment) amounts they find.
- But RACs will be audited, too, by a RAC Validation Contractor and the RAC's accuracy score will be published annually.

Who is our RAC?

- Georgia and South Carolina are in Region C, which is handled by Connolly Healthcare
- http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx

Types of Reviews (Audits)

- **RACs perform automated reviews when improper payment is *obvious*.**
- **In the case of claims that are *likely*, to contain errors, the RAC requests medical records from the provider to further review the claims (called a complex review).**
- **Claims paid prior to 10/1/07 cannot be reviewed by RAC; and going forward from 10/1/10, claims paid more than 3 years prior cannot be reviewed.**

Automated Review

- **Automated review occurs when a RAC makes a claim determination *without a human review of the medical record*. The RAC uses software designed to detect errors.**
- **For example, an automated review could identify when a provider is billing for more units than allowed on one day.**
- **A provider will not know that the RAC is looking at a particular claim until the provider is notified of an overpayment on a Remittance Advice (Remark Code N432 – "Adjustment based on a Recovery Audit.)**

Automated Review Flow Chart

RAC Makes a Claim Determination

The Collection Process (for an Automated Review)

Carrier (MAC) Issues Remittance Advice (RA) to Provider: N432 "Adjustment based on a Recovery Audit"

Day 1
RAC Issues DEMAND Letter to Provider
Appeals Timeline starts on the date of the Demand Letter plus 5 calendar days.

"RAC discussion" period begins with receipt of the Demand Letter
(See next slides)

Day 41
Carrier (MAC) Recoups by Offset

Recoupment will NOT occur if:
- **Provider has paid in full or**
- **Provider filed appeal by Day 30.**

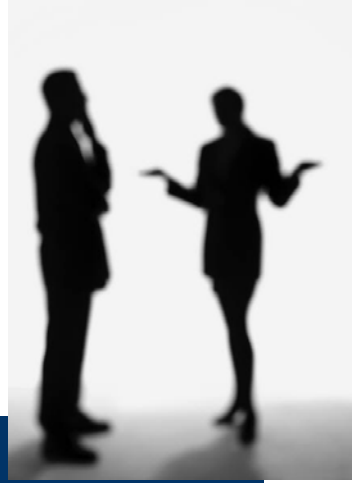
Interest begins to accrue 31 days from the receipt of the DEMAND LETTER whether or not you appeal

Demand Letter from an Automated Review

The Demand Letter will come directly from the RAC and will contain the following information:

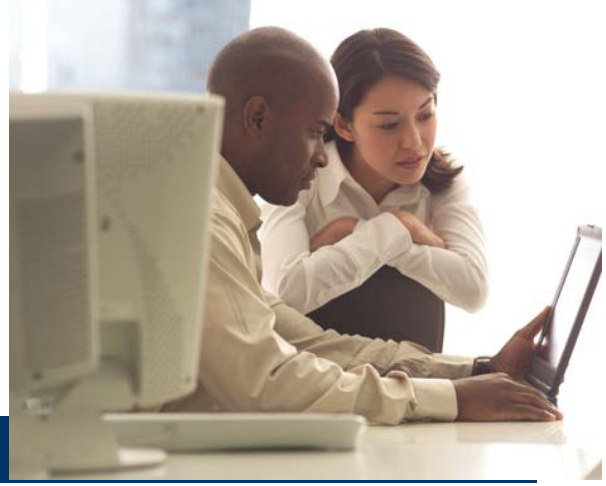
- Amount of the denial
- Method for calculating the denial
- Reason the original payment was incorrect
- Regulatory and statutory basis for the denial
- Provider's option to submit a rebuttal statement
- Provider's appeal rights (which are separate from the rebuttal process)
- Recoupment, payment and interest options for the provider and the associated timelines

RAC Discussion Period (for an Automated Review)



- The RAC will offer the provider a "period of discussion" for all denied claims. During the discussion period, the provider may provide additional information or documentation to the RAC for its consideration. This is NOT part of the formal Medicare Appeals process.
- For automated reviews, contact the RAC within 15 calendar days of the date of the Demand Letter to start discussion.
- The Appeals Clock is NOT put on hold for the discussion period and will run simultaneously from the date of the Demand Letter. For example, if a provider wishes to stop recoupment, it should simultaneously file an appeal with the Carrier (MAC) at the same time it is discussing the matter with the RAC.

Complex Review



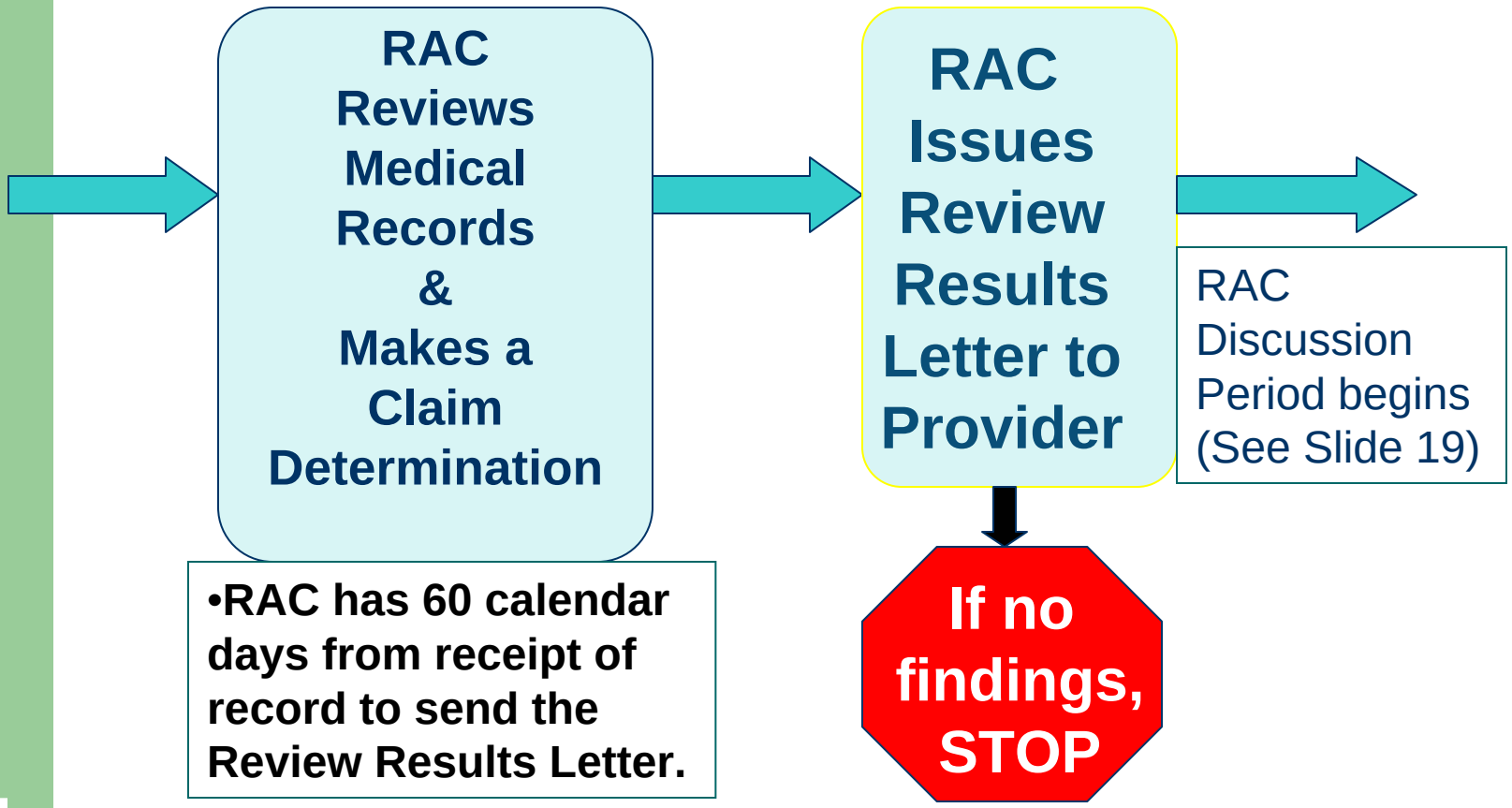
- **Complex Review occurs when a RAC makes a claim determination *using human review of the medical record*.**
- **Most complex reviews are medical necessity audits that determine whether the service was medically necessary and provided in the appropriate setting.**
- **For a group with 16+ physicians, a maximum of 50 records may be requested per 45 days. (Solo doctor, 10 records; 2-5 doctors, 20 records; 6-15 doctors, 30 records.) (Limits are established by using Group's NPI.)**
- **For other Part B billers (such as an IDTF), the records request is generally 1% of the average monthly Medicare services but not more than 200 records.**

Complex Review

Provider Submits medical records

- **Provider has 45 + 10 calendar days to respond but may request an extension.**
- **Claim is denied if no response.**

Complex Review continued:



- **RAC has 60 calendar days from receipt of record to send the Review Results Letter.**

The Collection Process (for a Complex Review)

Carrier (MAC) Issues Remittance Advice (RA) to Provider: N432 "Adjustment based on a Recovery Audit"

Day 1 RAC Issues DEMAND Letter to Provider

Appeals Timeline starts on the date of the Demand Letter plus 5 calendar days.

Day 41 Carrier (MAC) Recoups by Offset

Recoupment will NOT occur if:
- **Provider has paid in full or**
- **Provider filed appeal by Day 30.**

Interest begins to accrue 31 days from the receipt of the DEMAND LETTER whether or not you appeal

Medical Record Requests Letter (Complex Review)

- If RAC is reopening claims that were paid over one year prior to the date of the Medical Record Request Letter, the letter must contain an adequate description of the RAC's "good cause" to do so.
- Providers may submit scanned images of records to the RAC on CD or DVD (contact RAC for requirements). In 2010, providers may send electronically.

Review Results Letter from a Complex Review

The Review Results Letter will be issued on a per claim basis, will come directly from the RAC, and will contain the following information:

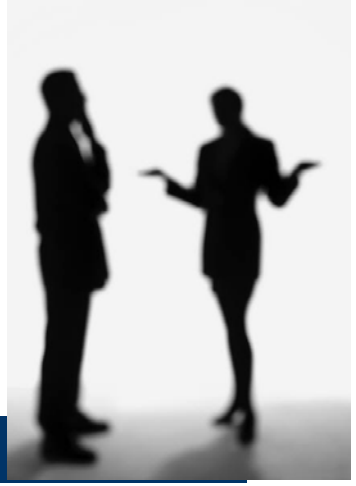
- Identification of the provider
- Reason for conducting the review
- Narrative description of the improper payment (if found) stating the specific issues involved that created the improper payment and any pertinent issues
- Findings for the claim including a specific explanation of why any services were determined to be non-covered or incorrectly coded, etc.

Demand Letter from a Complex Review

The Demand Letter will come directly from the RAC and will contain the following information:

- **Amount of the denial**
- **Method for calculating the denial**
- **Provider's option to submit a rebuttal statement**
- **Provider's appeal rights (which are separate from the rebuttal process)**
- **Recoupment, payment and interest options for the provider and the associated timelines**

RAC Discussion Period (for a Complex Review)



- The RAC will offer the provider a “period of discussion” for all denied claims. During the discussion period, the provider may provide additional information or documentation to the RAC for its consideration. This is NOT part of the formal Medicare Appeals process.
- For Complex Reviews, contact the RAC within 15 calendar days of the date of the Review Results Letter to start discussion.
- Entering into a “discussion” with the RAC may not prevent a subsequent Demand Letter from being issued if an overpayment was identified. Once the Demand Letter is issued, the date of the Demand Letter plus five calendar days will start the timeline for a Medicare appeal.

The appeals process can take 12-24 months per claim.

MEDICARE APPEALS PROCESS

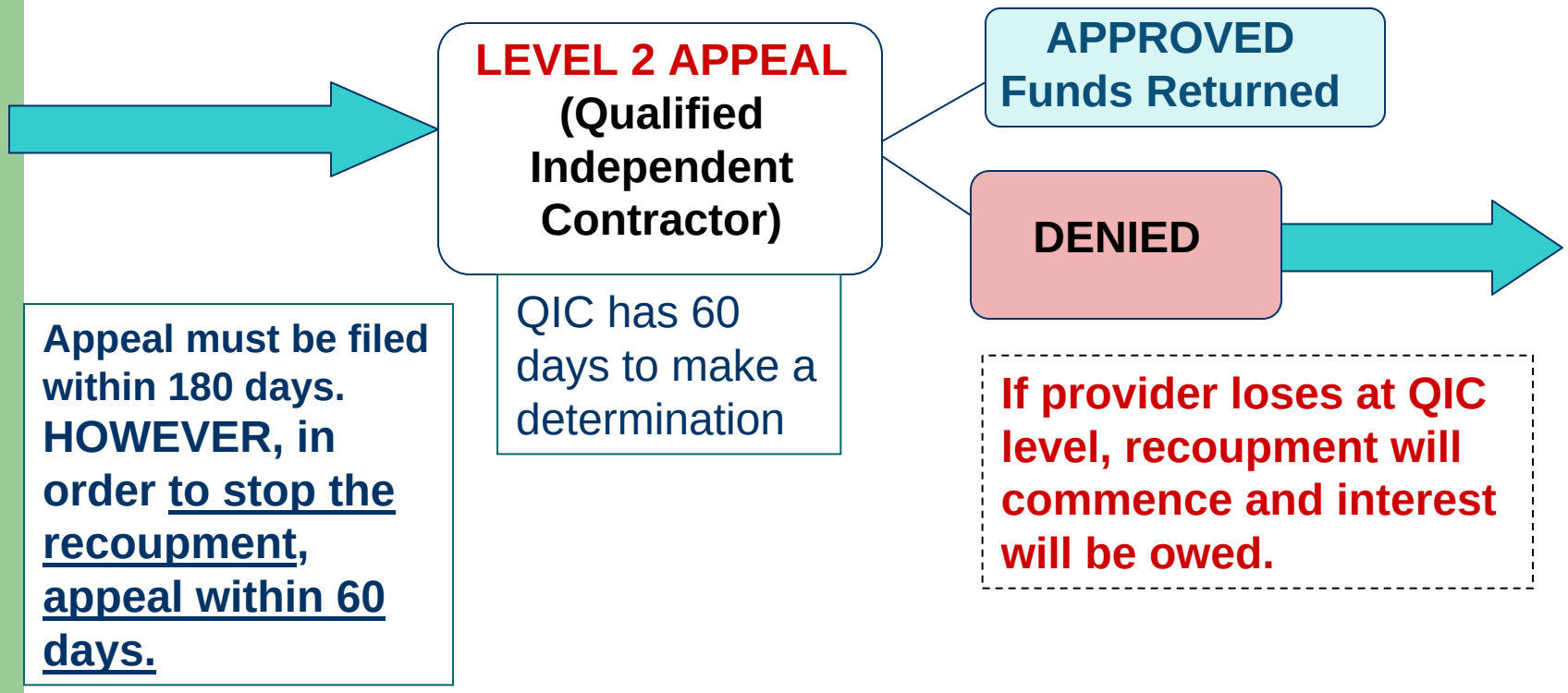
Date of Demand Letter plus 5 calendar days starts the Appeal Timeline

Appeal must be filed within 120 days. HOWEVER, in order to stop the recoupment, appeal within 30 days.

Carrier has 60 days to make a determination

Interest begins to accrue 31 days from the receipt of the DEMAND LETTER whether or not you appeal

MEDICARE APPEALS PROCESS CONTINUED:



MEDICARE APPEALS PROCESS CONTINUED:

LEVEL 3 APPEAL
(Administrative Law Judge)

APPROVED
Funds Returned

DENIED

Appeal must be filed within 60 days.

ALJ has 90 days to make a determination

MEDICARE APPEALS PROCESS CONTINUED:

LEVEL 4 APPEAL
(Appeals Council Review)

APPROVED
Funds Returned

DENIED

Appeal must be filed within 60 days.

ACR has 90 days to make a determination

MEDICARE APPEALS PROCESS CONTINUED:

LEVEL 5 APPEAL
(Judicial Review in U.S. District Court)

APPROVED
Funds Returned

DENIED

Appeal must be filed within 60 days.

Summary

- Recovery Audit Contractors have been hired by Medicare to find and recover incorrect payments. RAC is paid a percentage of what they recover. The RAC for our clients is Connolly Healthcare.
- The RAC program involves Medicare Parts A&B only.
- The RAC will use its software to find obvious mistakes such as duplicates and unbundled codes. These are called Automated Reviews and we won't have to provide the RAC with medical records, so there is no limit to the number of claims they can review.
- RAC employees will review types of claims known to be at a risk for containing errors such as lacking medical necessity. These are called Complex Reviews and we will have to provide the RAC with medical records, but there is a limit to the number of records they can request.
- RAC will inform us of the results by Remark Code N432 on the RA and Review Results (only for Complex) and Demand letters.
- We can have discussions with the RAC about their findings and we can appeal to Medicare.

SOME TIPS

- **Perform “Defense Audits” -- Do self-audits and file corrected claims because the RAC cannot pick up the prior incorrect claims.**
- **RACs will try to identify payments for medically unnecessary services, incorrectly coded services, services performed in a medically unnecessary place of service type (i.e. patient was hospitalized when they could have been treated on outpatient basis), claims not supported by documentation, duplicate claims, claims filed primary to Medicare when Medicare was secondary, and other new improper claims issues that come to light.**

Some Tips continued:

- **Check the RAC & CMS websites for new issues they will be auditing. www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx & www.cms.hhs.gov/rac**
- **RACs are not permitted to make denials for minor omissions such as missing dates or signatures.**
- **The RAC is permitted to educate providers only on the RAC's business, its purpose and process. RACs are NOT permitted to educate providers on Medicare policy.**

Some Tips continued:

- The RACs are not allowed to target claims solely because they are high dollar.
- Claims previously reviewed by any contractor for any reason are off-limits to the RACs.
- If an overpayment is identified by the RAC, the provider must also refund the patient or the secondary payer any amounts collected from them.

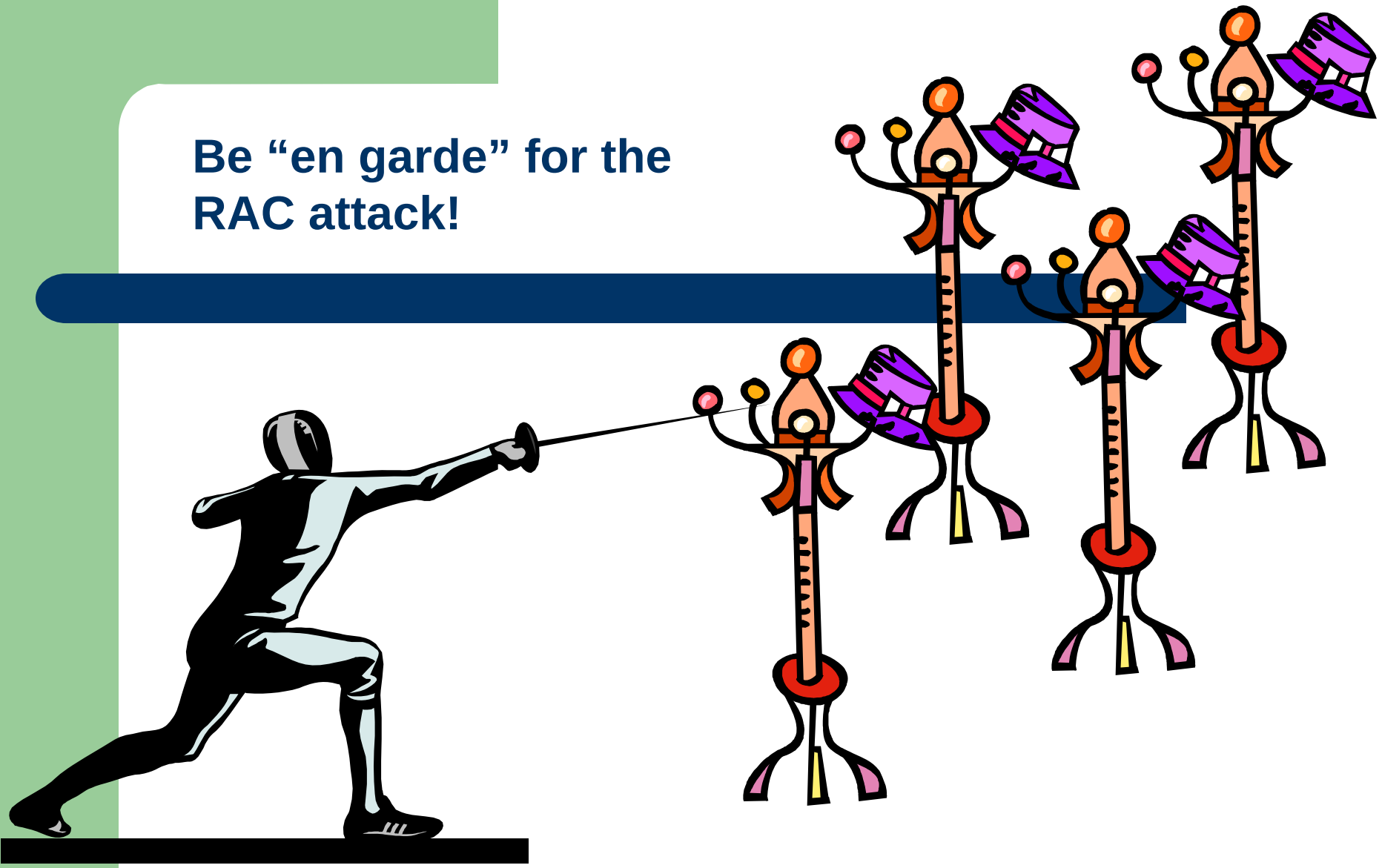
Some Tips continued:

- **The RAC is permitted to ask for medical records for the same issue every 45 days; so if you believe you have an extensive incorrect claims issue, do a self-audit and work out a deal with the Carrier for repayment so the RAC is not involved. (It will cut the RAC out of their percentage.)**
- **There is no claims limit for Automated Reviews because no medical records are requested.**

What RAC Means for Your Job Duties

- **EVERYONE** – If mail lands on your desk from the RAC, give it to _____ ASAP (keep it in the envelope for the postmark)
- **Coding** – Your expertise will be needed for internal reviews as well as looking at the results from RAC audits
- **Medicare** – Watch for denial patterns that could raise flags so we can address the issues before RAC does
- **Reimbursement** – Watch for the remark code N432 "Adjustment based on a recovery audit" on remittance advices and report to _____ ASAP
- **Refund** – Overpayments identified by RAC also means secondary payors and/or patients may need to be refunded
- **Compliance** – Serve as contact and coordinator to make sure we act and respond within the required timeframes

Be “en garde” for the RAC attack!



PRESENTED BY

1125 Troupe Street
P.O. Box 3128
Augusta, Georgia 30914
(706) 737-4575
FAX (706) 731-5289

Cindy Shields, Compliance & Privacy Officer
Direct Phone Line 706 667 7406