

RAC Questions & Answers

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Medicare

Recovery Audit Contractors

Don't Be Left in the Dark

The [Centers for Medicare & Medicaid Services](#) (CMS) has begun implementation of the permanent Medicare [Recovery Audit Contractor](#) (RAC) program. The phases began in March 2009 and will be completed by the year 2010. Medicare providers should become informed about the RAC program and be proactively prepared should you be involved in RAC related activity.

Aspects of the RAC program are highlighted below in the form of questions and answers. These aspects of the RAC program relate to RAC claim reviews as reflected in CMS documentation. However, the RAC program may be modified or changed before and after implementation. Therefore, as providers, you should investigate and continue to monitor CMS's implementation and administration of the RAC program.

What is CMS's expansion schedule for the nationwide RAC program? ([Return to Top](#))

For purposes of the nationwide RAC program, CMS has divided the United States into [4 geographic regions](#). A single RAC will serve each region and perform the recovery audit services for all Medicare claim types in that region. CMS intends to phase in the RAC program starting March 1, 2009. CMS has released a revised [map](#) reflecting the RAC expansion schedule and showing the projected implementation date for each state.

Who will serve as contractors for the nationwide RAC program? ([Return to Top](#))

In October 2008, CMS announced the contractors for the nationwide RAC program. The RACs and their respective regions are:

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- ✓ Do the RACs replace the other entities that review claims for accuracy of payment or investigate physicians' claims?
- ✓ How can I identify a RAC recovery versus a request for refund from other sources?
- ✓ What will prevent RACs and other Medicare contractors from reviewing the same claims?
- ✓ Will RACs be permitted to review claims related to physician evaluation and management services?
- ✓ Could a provider's self audit preclude RAC review?
- ✓ How will overpayments be recovered?
- ✓ Is there limitation on recovery of small overpayments found by the RAC?
- ✓ Will interest accrue on overpayment determinations?
- ✓ Will RACs be able to compromise and/or settle overpayments?
- ✓ Will providers be able to utilize the Medicare appeals process?
- ✓ How can providers prepare for the RAC program's nationwide implementation?

- [Diversified Collection Services, Inc.](#) - Region A - initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York. Contact number 1-866-201-0580.
- [CGI Technologies and Solutions, Inc.](#) - Region B – initially working in Michigan, Indiana and Minnesota. Contact number 1-877-316-7222.
- [Connolly Consulting Associates, Inc.](#) - Region C – initially working in South Carolina, Florida, Colorado and New Mexico. Contact number 1-866-360-2507.
- [HealthDataInsights, Inc.](#) - Region D – initially working in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona. Contact number 1-866-590-5598.

However, CMS reports that [PRG Schultz, USA, Inc.](#) will serve as a subcontractor to [HealthDataInsights, Inc.](#), [Diversified Collection Services, Inc.](#) and [CGI Technologies and Solutions, Inc.](#) in Regions A, B and D. CMS also reports that [Viant Payment Systems, Inc.](#) will serve as a subcontractor to [Connolly Consulting Associates, Inc.](#) in Region C. Each subcontractor has negotiated different responsibilities in each RAC region (including some claim review).

[Additional states](#) will be added to each RAC region in 2009 with some implementations delayed to August 2009 due to changes in the contractors who process claims (Medicare Carriers changing to Medicare Administrative Contractors).

Whose claims can be reviewed by the RAC? [\(Return to Top\)](#)

Anyone who submits a claim for services or products under Medicare Part A or Part B (including physicians, providers such as hospitals and nursing facilities, and suppliers such durable medical equipment companies) may have claims reviewed by the RAC.

Aren't RACs focusing on hospital claims? [\(Return to Top\)](#)

Initially, during the RAC demonstration project, the RACs focused on hospital-based services. This did not limit their review and recovery to services billed by the hospitals but rather included services billed by physicians at these facilities. Under the permanent RAC program, the focus is not limited to hospital claims. Claims from physicians, practitioners, or any other provider of service billing to Medicare Part A or Part B may be included in claims reviewed by the RAC.

Do RACs review claims paid by Medicare Advantage Managed Care plans? [\(Return to Top\)](#)

No. The RAC reviews are limited to claims paid under the traditional Medicare Fee-for-Service program. Part D, prescription drug plan claims, are also excluded.

What improper payments will be subject to RAC review? [\(Return to Top\)](#)

RACs may attempt to identify improper payments resulting from:

- incorrect payment amounts (except where CMS directs contractors otherwise);
- non-covered services (including services that are not reasonably necessary);

- incorrectly coded services (including DRG miscoding); and
- duplicate services.

For purposes of the RAC program, an "improper payment" will be an overpayment or underpayment. Therefore, situations where a provider submits a claim with an incorrect code, but the mistake does not change the payment amount, will not be considered an improper payment.

What improper payments will not be subject to RAC review? [\(Return to Top\)](#)

RACs may not attempt to identify improper payments arising from:

- services provided under a program other than Medicare fee-for-service;
- the cost report settlement process;
- claims more than 3 years past the initial determination date;
- claim paid dates earlier than October 1, 2007;
- claims where the provider is without fault;
- the random selection of claims;
- claims with special processing numbers (e.g., claims in Medicare demonstrations); or
- prepayment review.

What criteria will be used by the RACs in determining the medical necessity of services related to a claim? [\(Return to Top\)](#)

The RAC shall consider a service to be reasonable and necessary if the RAC determines that the service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the Clinical Trials NCD, are considered reasonable and necessary); and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 - 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 a setting appropriate to the patient's medical needs and condition;
 - Ordered and furnished by qualified personnel;
 - One that meets, but does not exceed, the patient's medical need; and
 - At least as beneficial as an existing and available medically appropriate alternative.

Preventive medicine services covered by Medicare (e.g., flu shots, covered screening services provided within frequency limitations) will not be subject to reasonable and necessary criteria for services provided for diagnosis or treatment of an illness or injury.

How far back can RACs look in reviewing claims? [\(Return to Top\)](#)

RACs are limited to a 3-year look back. The look back period will be counted starting from the initial determination date and ending with the date a RAC issues a medical record request (for complex reviews) or the date of the overpayment notification letter (for automated reviews). The initial determination date will be the claim paid date. However, RACs may not review claims with paid dates earlier than October 1, 2007. Therefore, at the onset of the nationwide RAC program, there may be situations in which the look back period is initially less than 3 years. For example, if CMS implements the RAC program in Indiana in March 2009, the RAC serving Indiana will only be able to review claims with paid dates from October 1, 2007- March 2009. However, by December 2009, the RAC serving Indiana will be able to review claims with paid dates from October 1, 2007- December 2009.

What types of determinations may RACs make? [\(Return to Top\)](#)

RACs may make any or all of the following determinations:

- coverage determinations;
- coding determinations; and
- other determinations (e.g., duplicate claim determinations).

Will RACs have to follow Medicare policies when making determinations? [\(Return to Top\)](#)

When making determinations, RACs will be expected to comply with:

- national coverage determinations;
- coverage provisions in interpretative manuals;
- national coverage and coding articles;
- local coverage determinations;
- local coverage/coding articles in their jurisdiction; and
- relevant joint signature memorandums supplied by CMS.

How will RACs identify issues to review for improper payments? [\(Return to Top\)](#)

RACs will use proprietary software to analyze claims for possible improper payments. Based on the RAC demonstration, RACs may also investigate issues already highlighted in HHS [Office of Inspector General](#), [U.S. Government Accountability Office](#) and [comprehensive error rate testing](#) reports. However, before pursuing a new issue, RACs will need to obtain CMS approval. CMS has contracted with [Provider Resources, Inc.](#) to serve as a validation contractor. CMS expects that the validation contractor will work with CMS to review and approve new issues.

Will providers be informed about the issues RACs intend to review? [\(Return to Top\)](#)

RACs will post the issues they intend to review on their respective websites. However, CMS reports that, if a RAC is investigating a new issue, a provider might receive a medical record request letter for an issue not identified on a RAC website. According to CMS, such a request should be for a small sample size and used to make a decision on a RAC performing a widespread review.

Must I allow RAC to conduct an onsite review of my medical records? [\(Return to Top\)](#)

If the RAC attempts an onsite visit and the provider refuses to allow access to their facility, the RAC may not make an overpayment determination based upon the lack of access. Instead, the RAC shall request the needed records in writing.

How will RACs identify overpayments and underpayments? [\(Return to Top\)](#)

CMS will supply the RACs with a data file containing claims history followed by monthly updates. RACs will use proprietary software to analyze claims for possible improper payments. RACs will primarily identify overpayments and underpayments through 2 claim review methods. The 2 methods are referred to as "automated review" and "complex review."

What is automated review? [\(Return to Top\)](#)

Automated review will occur when a RAC makes a claim determination at the system level without human review of the medical record. As reported by the Center's for Medicare and Medicaid Services (CMS), there are only three situations when a Recovery Audit Contractor (RAC) can use an automated review to determine a claim was an overpayment and demand repayment. According to CMS, a RAC may demand repayment without reviewing your records only when:

- A statute, regulation, or national or local coverage determination states reimbursement for a service will always be an overpayment.
- The service is found to be a medically unbelievable service.
- You fail to produce a timely response to a medical record request.

By knowing the scenarios, you can predict how likely it is that you'll be receiving RAC letters. Use these scenarios to perform a pre-audit to find vulnerabilities in your billing.

What is complex review? [\(Return to Top\)](#)

Complex review will occur when a RAC makes a claim determination using human review of the medical record. RACs will use complex review when:

- the requirements for automated review are not met;
- there is a high probability (but not certainty) that a service is not covered; or
- no Medicare policy, article or sanctioned coding guideline exists.

Whenever needed for reviews, the RAC may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the RAC.

Will medical records be requested from providers for complex reviews? [\(Return to Top\)](#)

Yes. However, CMS will impose medical record request limitations. CMS has released a [document](#) outlining the current medical record request limitations. For physicians, based on the NPI submitted on your claims, the limitations are:

- Solo Practitioner - 10 medical records/45 days
- Partnership of 2-5 individuals - 20 medical records/45 days
- Group of 6-15 individuals - 30 medical records/45 days
- Large Group (16+ individuals) - 50 medical records/45 days

How long will providers have to respond to medical record requests? ([Return to Top](#))

A provider will have 45 calendar days to respond to a medical records request by submitting copies of the medical records. However, providers may be able to obtain an extension if an extension request is made within the 45 day response period. If a provider does not submit the requested medical records within 45 days, a RAC may deem a claim to be an overpayment.

Will RACs be required to pay for the medical records they request? ([Return to Top](#))

CMS reports that RACs will be required to pay for medical records associated with acute care inpatient prospective payment system hospital claims and long-term care hospital claims, currently 12 cents per page. However, RACs are permitted (but not required) to pay for medical records associated with other types of claims. The AMA has requested that RACs also be required to reimburse physicians for these expenses.

What types of standards will CMS impose for complex reviews? ([Return to Top](#))

When making a claim determination in the absence of a written Medicare policy, article or coding statement (a so-called individual claim determination), RACs will be required to utilize appropriate medical literature and apply appropriate clinical judgment. CMS will also require that a RAC's medical director be involved in examining the evidence used to make individual claim determinations. Similarly, RACs will be required to ensure that coverage/medical necessity determinations are made by RNs or therapists and coding determinations are made by certified coders. A provider may request the credentials of the individuals making medical review determinations and request to speak to a RAC's medical director regarding a claim denial.

Will providers receive the results of RAC reviews? ([Return to Top](#))

RACs will be required to advise providers of the results of automated reviews (including any coverage, coding or payment policy or article violated) only if an overpayment determination is made. However, RACs will be required to advise providers of the results of complex review (including any coverage, coding or payment policy or article violated) even if no improper payment is identified.

For complex reviews, what will be the time frame for notifying providers of any overpayments? ([Return to Top](#))

RACs will be expected to complete complex reviews and send a letter to providers with the complex review results within 60 calendar days of the receipt of the medical records. However, if an extended time frame is needed, RACs may request a waiver of the 60 day period from CMS. If an extended time frame for review is granted by CMS, a RAC will notify the provider.

How will underpayments be handled? ([Return to Top](#))

If a potential underpayment is found, a RAC will communicate the underpayment to the appropriate Medicare contractor. The Medicare contractor (not the RAC) will make any claim adjustments. However, RACs will be under no obligation to accept case files from providers for underpayment case review. CMS documentation also suggests that providers may not have official appeals rights in relation to underpayment determinations. Nevertheless, a provider may use any RAC rebuttal process and discuss the underpayment determination with a RAC.

What if a RAC finds both overpayments and underpayments? ([Return to Top](#))

In situations where a RAC identifies both overpayments and underpayments for a provider, the RAC will offset the underpayment from the overpayment.

Do the RACs replace the other entities that review claims for accuracy of payment or investigate physicians' claims? ([Return to Top](#))

No. Medicare Contractors, Comprehensive Error Rate Testers, and Program Safeguard Contractors will still perform claims review.

How can I identify a RAC recovery versus a request for refund from other sources? ([Return to Top](#))

The demand letters issued by the RAC should be addressed from the RAC and will instruct physicians or other providers to forward their refund checks to the appropriate address at the applicable Medicare contractor for their claims administration (MAC). All refund checks shall be payable to the Medicare program.

What will prevent RACs and other Medicare contractors from reviewing the same claims? ([Return to Top](#))

CMS will provide RACs with access to a RAC data warehouse. The data warehouse will be a web-based application and include all RAC identifications and collections. The data warehouse will also include excluded and suppressed claims, which will not be available for RAC review. Before beginning a claim review, a RAC will be required to use the data warehouse to determine if a claim is an excluded claim (i.e., a claim that has already been reviewed by another entity). To ensure that RACs do not interfere with potential fraud reviews or investigations, RACs will also be required to use the data warehouse to determine if a claim is a suppressed claim (i.e., claim that is part of an ongoing investigation).

Will RACs be permitted to review claims related to physician evaluation and management services? ([Return to Top](#))

The review of evaluation and management (E&M) services will be allowed under the RAC program. For instance, the review of duplicate claims or E&M services that should be included in a global surgery will be available for review. However, CMS reports that it will work with the [American Medical Association](#) and physician community prior to any reviews being completed regarding the level of the visit. CMS also reports that it will provide notice to the physician community before RACs are allowed to begin reviews of E&M services and the level of the visit. The AMA and multiple other medical specialties have sent a formal request to Medicare asking that this not include the level of service reported, due to the complexity of interpreting physician documentation to support the codes reported.

Could a provider's self audit preclude RAC review? [\(Return to Top\)](#)

If a provider does a self-audit and identifies improper payments, a provider may self disclose the improper payments to the appropriate Medicare contractor. If the Medicare contractor agrees that the payments were improper, CMS documentation suggests that the claims may be adjusted and excluded from RAC review. However, before any self-audit and/or self-disclosure, providers should seek appropriate guidance.

How will overpayments be recovered? [\(Return to Top\)](#)

When attempting to recover overpayments, RACs must follow applicable CMS regulations and manuals as well as the Federal debt collection standards. In fact, RACs will basically follow the same practices as Medicare contractors when sending demand letters. However, the appropriate Medicare contractor (not the RAC) will make any claim adjustments.

If a demand letter is received, a provider may repay an overpayment by check. However, the RAC program may also use recoupment (i.e., recovery of an outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness). The recoupment activities will be performed by the appropriate Medicare contractor. Alternatively, RACs may offer providers the ability to repay an overpayment through an installment plan. Depending on the length of the installment plan requested, a RAC may forward the request to CMS for review and approval.

As part of the overpayment recovery process, RACs will also initiate the process of referring debts to the [Department of Treasury](#) (DOT) for cross-servicing and collection activities. In fact, RACs may issue a written notice to providers with the appropriate intent to refer language. If an outstanding debt remains unresolved or not under a non-delinquent installment plan, CMS documentation suggests that RACs will send the debt to the appropriate Medicare contractor for referral to the DOT on or before the 130th day of delinquency. RACs will cease all recovery efforts once a debt is referred to the DOT.

Is there limitation on recovery of small overpayments found by the RAC? [\(Return to Top\)](#)

The RAC shall not attempt recoupment or forward any claim for adjustment if the amount of the overpayment is less than \$10.00. Claims less than \$10.00 cannot be aggregated to allow for demand.

The RAC shall not forward any claim for adjustment if the amount of the underpayment is less than \$1.00.

Will interest accrue on overpayment determinations? [\(Return to Top\)](#)

Interest will accrue from the date of the final determination and be charged on an overpayment balance or paid on an underpayment balance for each 30 day period that payment is delayed. Any payments received from a provider will be first applied to any accrued interest and then to any remaining principal balance.

Will RACs be able to compromise and/or settle overpayments? ([Return to Top](#))

RACs will not have the authority to compromise and/or settle overpayments. If a provider presents a RAC with a compromise, settlement offer or consent settlement request, the RAC will forward the offer or request and related documentation to CMS for direction.

Will providers be able to utilize the Medicare appeals process? ([Return to Top](#))

Claims identified as overpayments will be subject to the Medicare appeals process. The Medicare appeals process will remain the same for physicians under Medicare Part B and for Medicare Part A non-inpatient claims. CMS reports that the only difference under Medicare Part A is for claims under the hospital inpatient prospective payment system. For such claims, the first level appeal will go to the fiscal intermediary. CMS has released an [appeals process chart](#) for the nationwide RAC program. However, providers should still review CMS instructions, guidance and any appeals-related correspondence to ensure that they are properly navigating the appeals process for the RAC program.

Physicians may also choose to send a rebuttal of the findings directly to the RAC within 15 days of receiving the RAC's letter identifying an overpayment. Note, however, that this does not stop the clock on the 120 day time period during which you can request a redetermination (first level appeal) from your Medicare contractor. Physicians who choose to send a rebuttal to the RAC will want to either simultaneously file a request for redetermination to the Medicare contractor or carefully track the status of the rebuttal and be prepared to file the request for redetermination within the 120 time period, if needed.

Your rebuttal letter or request for redetermination should reference Medicare policy, statute, or information from the medical record documentation that refutes the reason for denial.

How can providers prepare for the RAC program's nationwide implementation? ([Return to Top](#))

Continue or implement ongoing compliance activities within your practice, including all staff from schedulers to physicians. There are a number of activities that providers can undertake to prepare for the implementation of the nationwide RAC program, including:

- Examine the RAC demonstration and CMS documentation on the RAC program to identify possible target areas;
- Educate staff to recognize and efficiently handle all requests for records from a RAC or other program integrity contractor with a structured protocol and log. Before copies of records are sent to a RAC, be sure that all information related to a service has been included (e.g., If you reference patient history collected on a questionnaire, include a copy of the questionnaire.);
- Maintain an awareness of services targeted by the Office of the Inspector General's work plan, services with high error rates found by Comprehensive Error Rate Testing (CERT) contractors, and services with very high utilization or cost. Focus of the RACs include consultations, E & M

services on the same date as a procedure, global periods, services provided incident to a physician's services, and relationships between a physician certifying durable medical equipment and the supplier of the durable medical equipment;

- Make sure that documentation is clear and complete for all services, including the date, signature, and credentials of the person ordering and /or providing the service (e.g., documentation of injection order by nurse practitioner and administration by medical assistant);
- If you do not have a designated compliance officer, this is a good time to designate and assign duties aimed at protecting your practice from errors and omissions in your practice's billing, coding and documentation. This person may also take the lead in logging and responding to records requests and/or refund requests received by the practice; and
- Know how to navigate the Medicare appeals process (and the possible arguments and defenses to RAC determinations).