

Updated April 1, 2009

The Recovery Auditor Contractors (RAC)

In January 2008, a report by the Office of Management and Budget (OMB) indicated that the Medicare program had paid a whopping \$10.8 billion in overpayments to providers in 2007. The Centers for Medicare and Medicaid Services (CMS) then implemented the Recovery Audit Contractor Demonstration program as a way to measure the program's cost-effectiveness in discovering improper Medicare payments to providers. The reasons for these overpayments were medically unnecessary services, incorrect coding, incorrect or missing documentation, reimbursements based on outdated fee schedules, or duplicate payments by Medicare contractors.

The three-year pilot program for RAC began in June 2005 in the three states that generate the highest volume of Medicare claims-California, Florida and New York. Subsequently, the program was expanded to three other states- Arizona, Massachusetts, and South Carolina. Six months before the program's conclusion, CMS directed the OMB to compile a report on the program. The RAC served the dual purpose of recouping the overpayments, refunding underpayments, and reporting recurring reasons for overpayments to Medicare. Medicare in turn, would foster provider education to decrease these rampant errors and develop edits, which would automatically reject flawed coding practices in Medicare contractors' payment systems. The RAC's strategy was to review claims in a manner similar to the Medicare contractors either by automatic review (if the RAC was able to easily determine an overpayment was due to a provider's violation of Medicare's billing guidelines) or by a complex review (if the RAC identified possible overpayment and asked the provider to submit the original medical record that were submitted to the Medicare contractor). According to the OMB's 2008 report on the Recovery Audit Contractors, every \$1 the RACs recouped cost Medicare 20 cents. Overall, the RACs recouped \$693.6 million to the Medicare Trust Funds. The contractors were paid a contingency fee based on the overpayments they received from the providers. CMS concluded that the program was financially advantageous to Medicare and decided to institute the program permanently beginning in the summer of 2008, with complete implementation nationwide by 2010.

During the RAC demonstration, CMS noticed a few hurdles, which caused some notable modifications for the permanent program. Those changes will allow CMS more oversight of the RACs. They include:

- Requiring RACs to have physicians for their medical directors and on-staff certified coders.
- Requiring RACs to refund contingency fees if the providers' appeal for overpayment request at any level is overturned (previously, RACs were only required to return fees if overturned at the first level of appeal)
- Commissioned Recovery Auditor Contractor Validation Contractors (RVC) to validate any new audits before RACs begin reviewing them for improper payments. RVCs will provide annual accuracy scores for each RAC. RVCs will

also review a sample size of claims periodically as well as act to ensure the RACs are auditing claims correctly.

- CMS changed the look back period from four years to three years, and established a maximum look back date of October 1, 2007.
- Requiring all RACs by 2010 to operate websites with tracking tools for providers to check the status of all RAC medical record requests- increasing the transparency of RACs
- RACs will accept imaged medical records on CD/DVDs
- Concerning the burden of physicians regarding the frequency that RACs request medical records, CMS placed limits on the medical record requests that RACs can make within a 45-day period. They are:
 - 10 medical records per 45 days per NPI for Solo practitioners
 - 20 medical records per 45 days per NPI for Partnerships (2-5 individuals)
 - 30 medical records per 45 days per NPI for Group Practices (6-15 individuals)
 - 50 medical records per 45 days per NPI for Large Groups (16+ individuals)
- To ensure that RACs will not interfere with the MAC implementation, there will be a RAC black out period 3 months before and after a region transitions from a carrier or fiscal intermediary to a RAC.
- CMS decided not to proceed with Medicare Secondary Payer RACs as they were not financially beneficial; these RACs were only able to recoup \$12.7 million.

During the demonstration, the RACs excluded certain claims from review, which were- incorrect levels of Evaluation and Management codes, Home and health services, claims involved in potential fraud investigation, payments made to providers under another demonstration program, claims previously reviewed by another Medicare contractor. The RACs focused mainly on auditing Hospital claims. Through a RAC data warehouse, contractors were able to update claims with a “no touch” status for RACs. This would reduce the burden of additional medical record requests on physicians. This database was also a storehouse for the RACs improper payment findings for CMS and the public. CMS created the database to facilitate activities of all the Medicare contractors (RAC, MAC, and Medicare contractors involved in the claims process). Econometrica, an independent contractor reconciled payment errors and claims amounts in this database. The RACs will audit Evaluation and Management codes in the permanent program. However, CMS does not have a definitive plan on this process and we are uncertain about the specific guidelines that CMS will use to audit E&M services. The RACs will post the new issues they will audit on their websites before they start reviewing these claims.

RACs will initiate the collection process by sending a demand letter to the affected providers. RACs will give these providers opportunities to discuss the improper payment determination during the “RAC Discussion Period” , which is outside the normal appeal process.

If the RAC concludes that you were overpaid, you have the option of appealing or deciding not to appeal.

If you decide to appeal the RAC's determination, you can:

- Pay the overpayment (OP) by check by Day 30 (no interest accrues) and file an appeal by Day 120.
- Allow recoupment by Day 41 (interest accrues on OP) and file for appeal by Day 120
- Disallow the recoupment by filing an appeal before Day 31
- Request for an extension and appeal by Day 120.

If you decide not to appeal the RAC's determination, you can:

- Pay by check on or before day 30 (no interest will accrue)
- Allow recoupment by Day 41 (you will pay the OP in addition to the interest accrued)
- Request or apply for an extended payment plan (accrue interest on OP)

There are four geographic jurisdictions for the RACs. On October 6, 2008, CMS announced the names of the new national RACs. The new RACs are:

- **Region A-Diversified Collection Services, Inc.** auditing practices located in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.
- **Region B-CGI Technologies and Solutions, Inc.** auditing practices located in Michigan, Indiana and Minnesota.
- **Region C-Connolly Consulting Associates, Inc.** auditing practices located in South Carolina, Florida, Colorado and New Mexico.
- **Region D-HealthDataInsights, Inc.** auditing practices located in Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.

CMS will add more states to each RAC region in 2009.

Since Vestibular function testing was one of the top services with overpayment recoupment from the RACs (13,805 claims with overpayments and \$1.4 million in Florida), here are some helpful tips:

- Review claims before submission to ensure accuracy of codes used, and medical records submitted
- Conduct an internal assessment to identify if you are in compliance with Medicare guidelines
- Determine and implement the corrective actions you need to take to prevent improper payments
- Remember that if a RAC notifies you of an overpayment, you can appeal

- Review medical records before submission to ensure documentation supports information entered on claim
- Ensure that you are aware of the improper payment trends that have been found in the Office of Inspector General and Comprehensive Error Rate Testing Programs' reports.
- Use the Academy's coding resources, guidelines, policy statements and other practice management resources to assist as you prepare your claims prior to submission

References

The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration. Accessed at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf> on October 15, 2008