FAQ: Medicare Recovery Audit Contractor Program

NOTE: The following information regarding the Recovery Audit Contractor Program is intended only as general information. Physicians and clinic managers with specific legal questions should seek the advice of an attorney.

How did the Recovery Audit Contractor Program start?

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed the Department of Health and Human Services to conduct a 3-year demonstration using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare Fee-For-Service (FFS) program. The demonstration program began in California, Florida and New York because they are the largest states in terms of Medicare utilization. It later included Massachusetts, South Carolina and Arizona.

The Tax Relief and Health Care Act of 2006 expanded the program by requiring the Centers for Medicare and Medicaid Services (CMS) to implement a permanent, national Recovery Audit Contractor (RAC) program by January 1, 2010—Minnesota's RAC was assigned in October of 2008.

What is the program intended to accomplish?

The program is intended to identify past improper overpayments and underpayments made on claims of health care services provided to Medicare beneficiaries. It is also intended to provide information to CMS and Medicare contractors that could help protect the Medicare Trust Funds by preventing future improper payments thereby lowering the Medicare FFS claims payment error rate.

Which providers might be audited?

Health care providers that might be audited include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Parts A and B.

Who will be conducting the audits in Minnesota, and how are the auditors paid?

In Minnesota, CGI Technologies and Solutions, Inc. of Fairfax, Virginia was selected to serve as the RAC.[1] Contractors are paid on a contingency-fee basis for both the overpayments and the underpayments that they find.

How far back are auditors looking, and what types of review will be conducted?

RACs will be reviewing up to four years of private claims (no claims submitted further back than October 1, 2007 will be reviewed). The claims look-back period is three years from the date of the claim paid.

RACs will be performing two types of review:

1. Automated Review: RACs use software to analyze claims and identify potential errors such as duplicate payments, fiscal intermediary errors, medical necessity and coding errors.

2. Complex Review: RACs request medical records from the providers because identification of improper payments is not evident from the claim alone. RACs review medical records in light of Medicare's national and local coverage determinations (or the standards of practice in cases for which no national or local coverage determinations exist) to determine whether the services are medically necessary and correctly coded. Medical records are reviewed within 60 days (RACs are required to pay for copying expenses). This is a subjective type of review and therefore can be appealed more easily.

How will I be notified of an audit?

A letter from the RAC will be sent to you via U.S. mail. The letter will explain the nature of the overpayment, how it was established, and the amount you owe. It will offer you the opportunity to apply for an extended repayment plan if the immediate repayment of the debt will cause a financial hardship.

Be sure to watch your mail closely because the time period in which you may submit more information and/or appeal is based on the date of the letter (more information about appeals is included below).

How can I prepare for a potential audit?

- Focus on good documentation that shows deliberate billing.
- Assign a contact person within your office to watch for letters and be responsible for document requests and responses.
- Create a method to track document production and communication with the RAC.
- Communicate with others in your office (consistent billing practices, etc).

1 CGI Technologies and Solutions, Inc. was awarded this contract based on a bidding procedure.

What are RACs looking for?

RACs are looking for overpayments and underpayments in providers' submitted claims. Overpayments can occur when claims do not meet Medicare's coding or medical necessity policies.

Underpayments can occur when providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed.

Common overpayment vulnerabilities that the RACs identified in the demonstration states included:[2]

Type of Provider	Description of Item or Service	Amount Collected Minus Cases Overturned on Appeal
Inpatient Hospital	Excisional debridement; IRF services following joint replacement surgery; Heart failure and shock; Surgical procedures in wrong setting; Respiratory system diagnosis with ventilator support; Extensive OR procedures unrelated to principal diagnosis	$117.2 m
Outpatient Hospital	Colonoscopy; Speech language pathology services; Infusion services	$4.7 m
Skilled Nursing Facility	Physical therapy and occupational therapy; Speech language pathology services	$3.4 m
Physician	Pharmaceutical injectables; Duplicate claims; Vestibular function tests	$5.2 m
Lab / Amb / Other	Ambulance services during a hospital inpatient stay	$2.0 m
DME	Items during a hospital inpatient stay or SNF stay	$3.0 m

I have received an audit letter. What do I do next?

Try to identify what the RAC is looking for so that you can adjust your record-keeping for future service billing. Track the records that you send for audit purposes.

The RAC will offer a 15-day rebuttal/period-of-discussion for providers. This is your opportunity to contact the RAC and provide additional information to the RAC to support the claim. Consider whether an attorney may be of assistance to you in determining which documents to submit (note: contacting an attorney is not required).

This 15-day rebuttal period is separate from the appeals process (discussed below). If you choose not to provide additional information within the 15-day period, you will need to respond to the RAC request within 45 days, or risk being denied future Medicare payments in the amount of the recoupment.

Both the 15-day rebuttal period and the 45-day response period begin on the date of the letter. Your prompt response is essential. You can also request an extension if you can demonstrate a need.

I disagree with the determination made by the RAC. How does the appeals process work?

Appealing an RAC determination is a complex, five-level process, and the assistance of an attorney may be helpful. A summary of the process is listed below. Note that some Medicare Part A claims are eligible for an expedited appeals process.[3]

1st Level of Appeal: Redetermination

Within 120 days of the RAC denial, an appeal can be filed whereby the medical carrier is contacted and asked to conduct a redetermination of the claim. If the appeal is filed within the first 40 of the 120 days, it will prevent recoupment of payment through the first and second levels of the appeals (for favorable outcomes).

A copy of the Redetermination Form (CMS-20027) can be downloaded by visiting the following URL: www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf

A decision (either in the form of a letter or a revised remittance advice) will be issued within 60 days of receipt of the redetermination request.

2 Centers for Medicare and Medicaid Services: CMS RAC Status Document, FY 2007; Status Report on the Use of Recovery Audit Contractors (RACs) In the Medicare Program, February 2008.

3 See: www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf

2nd Level of Appeal: Reconsideration

Within 180 days of the receipt of a redetermination decision, a party can request that Qualified Independent Contractors (QICs) made up of a panel of physicians or other health care professionals conduct a review of medical necessity issues. A minimum monetary threshold is not required to request a reconsideration decision.

A copy of the Reconsideration Form (CMS-20033) will be mailed with the redetermination decision.

A reconsideration decision will be mailed to all parties within 60 days of receiving the reconsideration request. If the QIC will not be able to respond within that time period, it will inform the appellant of their right to escalate the case to an Administrative Law Judge (ALJ).

3rd Level of Appeal: Administrative Law Judge Hearing

Within 60 days of the receipt of the reconsideration decision, a party may request an ALJ hearing. Details regarding this procedure will be included in the reconsideration decision. Note that there is a minimum amount of money (noted in the appeal instructions) that must remain in controversy following the QIC's decision to appeal at this level.

ALJ hearings are usually held by video-teleconference or by telephone. An in-person hearing may be granted upon demonstration of good cause. Appellants also have the option of asking the ALJ to make a decision "on the record" (without a hearing).

The ALJ will usually issue a decision within 90 days of receipt of the hearing request, but this timeframe may be extended. If a decision is not issued within the applicable timeframe, the ALJ may grant the appellant the ability to escalate the case to the Appeals Council Level.

Fourth Level of Appeal: Appeals Council Review

Within 60 days of receipt of the ALJ's decision, a dissatisfied party may request a review by the Appeals Council. There are no minimum requirements regarding the amount of money in controversy.

The request must be submitted in writing in accordance with the instructions that are included with the ALJ decision.

In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. If the Appeals Council cannot issue a decision within that timeframe, it may grant the appellant the ability to escalate the case to the Judicial Review level.

Fifth Level of Appeal: Judicial Review in the U.S. District Court

Within 60 days of the Appeals Council decision, a party may request judicial review before a U.S. District Court judge. Note that there is a minimum amount of money (noted in the appeal instructions) that must remain in controversy following the Appeals Council decision to appeal at this level.

The request must be submitted in accordance with the instructions that are included with the decision of the Appeals Council.

How successful have claimants been in pursuing an appeal, and how long does it typically take?

As of August 31, 2008, 7.6% of all Parts A and B claims were overturned on appeal.[4] The average length of the appeals in the demonstration states was 12-24 months.

How much money has been recovered in the demonstration states thus far?

The demonstration (conducted in California, Florida, New York, Massachusetts, South Carolina and Arizona) resulted in over $900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008, and nearly $38 million in underpayments returned to health care providers.[5]

Where can I find further information?

- General information about RAC: www.cms.hhs.gov/RAC/
- Medicare financial management (RAC information begins in section 100): www.cms.hhs.gov/manuals/downloads/fin106c04.pdf
- Medicare appeals process: www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf

Who can I contact at the Minnesota Medical Association about questions relating to this FAQ?

MMA attorney, Karolyn Stirewalt can be reached at (612) 362-3738 or by email at KStirewalt@mnmed.org.

4 www.cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf

5 www.cms.hhs.gov/RAC/Downloads/Appealupdatethrough63008ofRACEvalRept.pdf (website visited 1/21/09).