
Medicare Recovery Audit Contractor (RAC) Program

Educational Presentation Material

Topics

- What is the RAC program
- Who is affected by RACs
- Timeline for Implementation
- How does the RAC program work
- Getting Ready for your RAC

What is the RAC Program

- Tax Relief and Healthcare Act of 2006 (section 302) requires a permanent and nationwide RAC program be implemented no later than January 1, 2010
- The RAC program is charged with identifying improper over and under payments for Medicare fee for service claims
- Ultimate goal is to implement actions that will prevent future improper payments

What is the RAC Program

- CMS has divided the country into four geographic locations and awarded contracts to different organizations for each of these locations
- These four contractors in turn have subcontractors for certain functions (this was the resolution of the protest filed after the initial contracts were awarded)

RAC Subcontractor Information

Region A: DCS

Subcontractors: PRG Shultz, iHealth Technologies and Strategic Health Solutions

Region B: CGI

Subcontractor: PRG Schultz

Region C: Connolly Consulting

Subcontractor: Viant, Inc.

Region D: HDI

Subcontractor: PRG Schultz

Reference: <http://www.cms.hhs.gov/RAC/Downloads/>

What is the RAC Program

- RACs will use data mining techniques to identify claims for review
- RAC must get approval from CMS for the types of issues they want to target
- Their review must follow the same Medicare policies as carriers, fiscal intermediaries and MACs
- RACs are required to employ clinical and certified coding staff as well as a medical director

What is the RAC Program

- RACs are paid by contingency fee based on the amount of over and under payments they identify
- Contingency fee must be returned if RAC loses at any level of an appeal
- Each RAC's contingency fee is established by their contact with CMS and will vary by RAC (currently 9.0% - 12.5%)

Who is affected

- Any provider who bills fee for service Medicare claims will be subject to RAC review
- Volume of claims reviewed will vary based on type of provider and the number of Medicare claims they submit
- Implementation of program will be staggered through end of 2009 by provider type

Timelines for Implementation – Initial Steps to be Completed

- CMS will schedule in-person education and outreach sessions for each region
- Audits and record reviews will not start in a state until educational sessions have been conducted
- RAC must complete the process for obtaining claims data and establishing agreements with claims processing contractors
- RAC requests CMS approval for types of reviews it wishes to conduct
- Activity will phase in over the spring and summer of 2009 – exact timeline will be based on region and type of claims review

How Does the RAC Program Work

- Two types of reviews are performed
 - Automated (does not require submission of medical records)
 - Complex (provider submits copies of medical records)
- RACs will be reviewing claims paid on or after October 1, 2007 (they can go back up to three years from when claim is paid)
- RACs have a limit on the numbers records they can request per NPI

Automated Reviews

- Performed using software tools to detect certain types of error conditions
- Potential errors identified must be clearly a non covered service or incorrect application of coding rules
- Must be supported by Medicare policy, approved article or coding guideline

Complex Reviews

- Determination is made based on review of the medical record
- Potential issues requiring complex review are those with high probability of non covered service or there is no definitive Medicare policy, Medicare article or Medicare-sanctioned coding guideline
- RAC must use appropriate medical literature and clinical judgement when determining medical necessity

Complex Reviews

- Provider has 45 days to submit medical record to RAC from date of the request letter
- RAC must make one additional contact with provider if a record is not received in the time allotted before it denies the claim for failure to submit documentation
- Review must be completed within 60 calendar days from receipt of the record

Record Limits – All claim types

Updated December 2, 2009

- Information posted on RAC website:
<http://www.cms.hhs.gov/RAC/Downloads/DRGvalidationADRlimitforFY2010.pdf>
- The RAC first must calculate the relevant provider's documentation limit and, therefore, must ensure that the number does not exceed the applicable cap as follows:
 - 1% of all claims submitted by the provider in the previous calendar year/45 days (regardless of paid or denied claim status) with a cap of 200 for the first 6 months
 - Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located.

Record Limits – All claim types

Updated December 2, 2009

- Applies across all of a provider's claim types, including professional service claims
- RAC has discretion to the actual composition of the requests. Example: RAC may request up to the full limit of one particular type of claim (ie. inpatient) even though this type may only represent a fraction of the provider's total claim volume.
- Caps will be based on submitted claim volume (greater than 100,000 annual claims may have cap of 300)
- Caps may be exceeded if RAC has been granted permission

RAC Determinations

- Coverage – if service is not covered the RAC can identify partial or full overpayment
- Coding – if service coded incorrectly the RAC can identify partial or full over or under payment
- Other – the RAC can identify partial or full over or under payment for other conditions such as failure to apply correct payment policy or duplicate claim submission

Reviewing RAC Determinations and the Appeal Process

- This process starts with a demand letter (automated review) or review results letter (complex review)
- ‘discussion period’ for denied claims allows provider to submit additional information or documentation if it disputes the finding
- Appeals timeline starts when letter received by provider
- Five levels of appeal starting with fiscal intermediary and ending with judicial review in US District Court

Getting Ready for Your RAC

This section should comprise the facility specific slides that describe what they have and/or are doing so far to prepare for the RAC

Describe Your Hospital RAC Process

- Identify key staff and their roles
- Describe your process flow
 - Receiving, processing and tracking requests
 - Managing appeals
- Describe process for corrective actions taken based on internal or RAC findings

Getting Ready for Your RAC

- Review demonstration RAC findings (www.cms.hhs.gov/rac) and permanent RAC findings (when available) to identify the types of improper payments found
- Look for patterns of review by OIG and CERT reports for ideas of other potential review areas

Getting Ready for Your RAC

- Perform internal reviews to determine compliance with Medicare requirements
- Use data mining techniques to identify if you have any patterns similar to issues identified by past RAC reviews
- Review RAC contractor URLs across all regions to help identify overlap of target areas and anticipate what might be coming.

Managing Record Requests

- Determine how to handle off site or electronic documents until review and/or appeal process is complete
- Use tracking system to manage request process and status of each record