

April 20, 2009

MEDICARE RECOVERY AUDIT CONTRACTORS (RACs): PERMANENT PROGRAM BASICS

AT A GLANCE

The Issue:

Initially established as a demonstration project in three states in 2005, the Medicare Recovery Audit Contractor (RAC) program is charged with identifying improper Medicare fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. At the end of 2007, two additional states were added to the demonstration before it ended on March 27, 2008. Congress expanded the program to all states and made it permanent in Section 302 of the *Tax Relief and Health Care Act of 2006*.

In October 2008, the Centers for Medicare & Medicaid Services (CMS) named four permanent RACs. However, one month later, CMS was required to impose an automatic stay on the rollout of the program due to protests filed by two unsuccessful contract bidders. On February 4, 2009, CMS announced that both companies had withdrawn their protests, allowing the RAC program to proceed immediately with no further delays. CMS also announced that both companies will serve as subcontractors to the four permanent RACs. Currently, the RACs and CMS are conducting educational sessions with providers in several states and more will continue through the spring and summer.

This advisory aims to provide an overview of the permanent RAC program. It describes the guidelines RACs must follow, the requirements for hospitals and the timeline for the national rollout of the program. At this time, CMS continues to refine RAC program policies and procedures. Program changes continue to be addressed on an ongoing basis and will continue as the rollout proceeds this spring.

Our Take:

While the AHA has worked successfully to improve the RAC program, several concerns remain about the program in its current form. The AHA will continue to urge CMS and Congress to make changes. Please visit www.aha.org/rac for additional AHA member resources and an updated list of upcoming educational events.

What You Can Do:

Please share this advisory with the following key staff:

- Hospital leadership, including executive, medical and financial leaders, corporate compliance officers and legal counsel;
- Physicians, nurses, therapists and others making clinical decisions regarding medical record documentation; and
- Coding, billing and medical records staff.

Further Questions:

Please contact Alyssa Keefe or Rochelle Archuleta at (202) 638-1100 or e-mail RACinfo@aha.org.

Acknowledgements:

The AHA would like to thank the CMS personnel for their input into this advisory.

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BACKGROUND

Congress established the Medicare Recovery Audit Contractor (RAC) program as a three-year demonstration in the *Medicare Modernization Act of 2003* (MMA). The demonstration began in California, Florida and New York and expanded to Massachusetts and South Carolina in 2007 before ending on March 27, 2008. In the *Tax Relief and Health Care Act of 2006*, Congress made the program permanent and called for expansion to all 50 states by no later than January 1, 2010.

RACs seeks to identify improper Medicare payments – both overpayments and underpayments – using automated proprietary software programs to identify potential payment errors, such as duplicate payments, claims processing contractors' mistakes and coding errors. In addition, RACs can request medical records to review coverage or coding documentation for overpayments or underpayments as part of "complex reviews." RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they collect from providers. In March 2008, CMS noted that \$992 million dollars had been identified in improper payments during the demonstration program.

In October 2008, the Centers for Medicare & Medicaid Services (CMS) named four permanent RAC contractors. One month later, CMS was required to impose an automatic stay on the RAC program when two unsuccessful bidders (PRG Schultz USA, Inc. and Viant Payment Systems, Inc.) filed protests with the Government Accountability Office (GAO). On February 4, 2009, CMS announced that both companies had withdrawn their protests, allowing the RAC program to proceed immediately. CMS also announced that both PRG Schultz and Viant will serve as subcontractors to the four permanent RACs.

This advisory provides an overview of the RAC permanent program. It is intended to describe the guidelines RACs must follow, the requirements for hospitals and the expected timeline for the national rollout. CMS is still refining the RAC program's policies and procedures. Changes continue to be rolled out on an ongoing basis and are expected to continue into the spring. While the AHA has worked successfully to improve the RAC program, several concerns remain about the program in its current state. We will continue to urge CMS and Congress to make changes. Please continue

to participate in AHA educational sessions and watch for continued updates at www.aha.org/rac.

FREQUENTLY ASKED QUESTIONS

How are RAC assignments determined?

CMS divided the country into four regions (A, B, C and D), as noted on the map on page 4. On October 6, 2008, CMS announced the new permanent RACs and their assigned regions (see table below). CMS noted that the contractors were selected based on “a best value determination for the federal government that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee.”

The contract awards one-year contracts with option years not to exceed 60 months. For example, if CMS determines at the end of the first year that one of the contractors is not meeting expectations, it may elect not to renew the option for the second year.

RAC Region	Medicare Recovery Audit Contractor	States in Region
A	Diversified Collection Services, Inc. of Livermore, California <i>Subcontractors: PRG Schultz, Health Technologies, and Strategic Health Solutions</i>	MD, DC, DE, NJ, PA, NY, ME, VT, NH, MA, CT and RI
B	CGI Technologies and Solutions, Inc. of Fairfax, Virginia <i>Subcontractor: PRG Schultz</i>	MI, MN, WI, IL, IN, KY and OH
C	Connolly Consulting Associates, Inc. of Wilton, Connecticut <i>Subcontractor: Viant</i>	CO, NM, TX, OK, AR, LA, MS, TN, AL, GA, NC, SC, WV, VA, FL and Puerto Rico
D	HealthDataInsights, Inc. of Las Vegas, Nevada <i>Subcontractor: PRG Schultz</i>	WA, OR, CA, AK, HI, NV, ID, MT, UT, AZ, WY, ND, SD, NE, KS, IA and MO

What is the role of the RAC subcontractor?

On February 9, 2009, CMS announced that in addition to the four permanent RAC contractors – Diversified Collection Services, Inc.; CGI Technologies and Solutions; Inc.; Connolly Consulting Associates, Inc.; and HealthDataInsights, Inc. – two additional companies will serve as subcontractors – PRG-Schultz and Viant. Their subcontractor duties will include the following:

- **Viant.** As a subcontractor to Connolly Consulting, the RAC for Region C, Viant will conduct complex reviews of hospital inpatient claims and physician-administered J-codes in North Carolina, South Carolina, Virginia and West Virginia.
- **PRG-Schultz.** PRG Schultz will act as a subcontractor to Diversified Collection Services (Region A), CGI (Region B) and Health Data Insights (Region D). In this capacity, PRG Schultz will audit Part A/B Medicare Administrative Contractor (MAC) claims in Maine, New Hampshire, Vermont, Minnesota, Wisconsin, Idaho, Oregon and Washington; home health claims in Regions A, B and D; and durable medical equipment claims in Region B.

Each subcontractor will work directly with the primary RAC(s) in its designated region(s). CMS has no formal contracting arrangements with the subcontractors.

Three of the four permanent RACs were involved in the demonstration program in some capacity:

- Diversified Collection Services (DCS) (Performant Audit & Recovery/DCS) operated in California as a secondary payer RAC;
- Connolly Consulting was the claim RAC in New York and Massachusetts;
- HealthDataInsights was the claim-level RAC in Florida and South Carolina;
- PRG Schultz, a current subcontractor, was the claim RAC in California; and
- Viant was a subcontractor to PRG Schultz.

What is CMS' plan and timeline for rolling out the permanent RAC program?

CMS is required to implement Medicare recovery auditing in all states by no later than January 1, 2010. Due to the delay in the implementation of the program, CMS has revised its phase-in plans by condensing the rollout schedule as noted in the map on page 4.

outreach sessions) to begin until May 2009. However, this timeline is subject to change at any time.


*More information on the “new issue review process” is located on page 10 of this advisory.

Who is my point of contact at both my RAC and CMS if I have questions regarding the RAC program?

All management of the RAC program is being handled by the CMS Central Office in Baltimore, MD. In addition to a RAC director and deputy director, CMS has named four project officers to oversee operations in each of the four RAC regions. Contact information for CMS project officers and RAC customer service is listed below.

Connie Leonard, Director
 Director, Division of Recovery Audit Operations
 Centers for Medicare & Medicaid Services, Baltimore, MD
 Phone: (410) 786-0627
 E-mail: Connie.Leonard@cms.hhs.gov

CDR Marie Casey, RN, BSN, MPH
 Deputy Director, Division of Recovery Audit Operations
 Centers for Medicare & Medicaid Services, Baltimore, MD
 Phone: (410) 786-7861
 E-mail: Marie.Casey@cms.hhs.gov

RAC Region	Medicare Recovery Audit Contractor	RAC Contact Information	CMS RAC Project Officers
A		1-866-201-0580	Ebony Brandon Ebony.Brandon@cms.hhs.gov (410) 786-1585
B		1-877-316-7222 e-mail: racb@cgi.com	Scott Wakefield Scott.Wakefield@cms.hhs.gov (410) 786-4301
C		1-866-360-2507 www.connollyhealthcare.com	Amy Reese Amy.Reese@cms.hhs.gov (410) 786-8627
D		Part A: 1-866-590-5598 Part B: 1-866-376-2319 e-mail: racinfo@emailhdi.com	Kathleen Wallace Kathleen.Wallace@cms.hhs.gov (410) 786-1534

All general questions related to the RAC program can be sent to RAC@cms.hhs.gov. You also can visit the Frequently Asked Questions section

(http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_pv=4.497) of the CMS Web site, or the RAC section (www.cms.hhs.gov/rac) for program updates.

What type of customer service must RACs provide?





Each RAC must provide the following services:

- A Toll-free Number. A RAC must provide a toll-free customer service telephone number in all correspondence sent to Medicare providers. The customer service number must be staffed by qualified personnel during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone. The toll-free numbers are noted above.
- Knowledgeable Customer Service Staff. CMS requires that the staff answering the customer service lines be knowledgeable about the RAC program. The staff must have access to all identified improper payments and must be knowledgeable about recovery methods and initiating an appeal. A RAC staff person responsible for the specific overpayment is required to return calls within one business day. A translator for Spanish-speaking providers must be available.
- Quality Assurance Program. A RAC must use a quality assurance program to ensure that all customer service representatives are knowledgeable, respectful to providers and provide timely follow-up calls when necessary. CMS staff may monitor these calls.
- Timeliness in Response to Written Correspondence. A RAC is required to respond to written correspondence within 30 days of receipt. Any correspondence a RAC receives indicating displeasure with the RAC in the overpayment identification or in the recovery methods used must be forwarded to CMS within 10 days.
- RAC Provider Outreach Plan. A RAC's provider outreach plan should include a customer service component and should be updated as needed. CMS may stop recovery work in a particular region if evidence leads CMS to believe the customer service plan is not appropriate and/or effective. This "stop order" would be effective until CMS is satisfied with all improvements made in the customer service area.
- Provider Education. A 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. As noted above, CMS is in the process of scheduling in-person education sessions in the yellow states scheduled for the first phase of the rollout. The remaining states (in blue) likely will have their sessions scheduled for later this summer.
- RAC Web Page. Each RAC is required by January 1, 2010 to develop and

maintain a Medicare RAC Web page to communicate helpful information to the provider community. Many of the RACs will have Web sites available prior to January 1, 2010. More information will be available from the RACs during their education and outreach sessions.

What is the contingency fee percentage for each RAC?

Upon awarding each of the RAC contracts, CMS released each of the contingency fee percentages on its Web site at www.fedbizops.gov. Each contingency fee is noted in the table below. The contractor with the lowest percentage contingency fee was allowed to pick the region of the country in which it wished to operate. These contingency fees are fixed for entire 60 months of the contract.

RAC Region	Medicare Recovery Audit Contractor	Contingency Fee Percentage
A		12.45%
B		12.50%
C		9.00%
D		9.49%

Will the RAC have to return its contingency fee if the denial is overturned in favor of the provider upon appeal?

If a RAC identifies an overpayment and that claim is then appealed by the provider, the RAC must return the contingency fee it collected for that overpayment if the outcome of the appeal (at any level) is found in favor of the provider.

Will a RAC get the same contingency fee for an underpayment as it will for an overpayment?

Yes. The contingency fee is the same regardless of whether the RAC identifies an overpayment or an underpayment.

What types of claims may RACs identify and review?

A RAC may attempt to identify improper payments on claims that are paid by carriers, FIs, MACs and other primary claims processing contractors in its jurisdiction. RACs are required to identify Medicare claims that contain improper payments for which payment was made, or should have been made, under Medicare Parts A or B. All Medicare fee-for-service providers including hospital inpatient and outpatient, long-term care hospitals, inpatient psychiatric, inpatient rehabilitation, skilled nursing, home health,

hospice, physician services and durable medical equipment suppliers are subject to RAC review. However, before a RAC reopens a claim that is more than one year past the date of initial determination, it must have “good cause.”

Note: The “good cause” standard for reopenings is defined as new evidence that was not available or known at the time a payment or appeals decision was made, or evidence that clearly shows the payment or appeal decision involved an obvious error or fraud. See AHA’s Medicare Appeals Member Advisory, available at <http://www.aha.org/aha/advisory/2009/090327-regulatory-adv.pdf>, for more information on this topic.

What is an example of an “improper payment”?

Improper payments include:

- incorrect payment amounts;
- incorrectly coded services (including Medicare Severity diagnosis-related group miscoding);
- non-covered services (including services that are not reasonable and necessary); and
- duplicate services.

The first two bullets noted above also may be found to be underpayments – another form of an improper payment.

Are Critical Access Hospitals subject to RAC review?

Yes, Critical Access Hospitals are subject to RAC review. Any payment adjustments will be reflected on the final Provider Statistical and Reimbursement Reports. If the cost report already has had a final settlement, the amount will be demanded and then offset against future claims, if not paid in full by the provider.

What types of claims are RACs NOT permitted to identify and review?

RACs are not allowed to identify improper payments arising from:

- Services provided under a program other than Medicare fee-for-service. For example, a RAC may not review payments in the Medicare managed care program, Medicare drug card program or drug benefit program.
- Cost report settlement process. A RAC may not identify and review cost report settlement issues such as indirect medical education and graduate medical education payments.
- Claims older than three years. The look-back period begins on the date the claim was originally paid and ends on the date of the medical record request letter (for complex reviews), the date of the demand letter (for automated reviews) or three years from original payment, whichever is sooner.

Note: The dates of correspondence outlined above for determining the look-back period for the RAC program under a complex review are different from the Medicare Policy Manual. Medicare regulations state that a look-back period starts from the original payment date of the claim to the redetermination date of the reviewing entity, not the date of the medical record request letter as noted above.

- Claims paid earlier than October 1, 2007.
- Claims where the beneficiary is liable for the overpayment because the provider is without fault. For example, a service that was not covered because it was not reasonable and necessary but the beneficiary signed an Advance Beneficiary Notice.
- Claims that are randomly selected or because they are high-dollar claims. A RAC may not target claims solely because they are high dollar, but may target claims that are high dollar and contain other information that leads the RAC to believe there are overpayments involved.
- Claims involved in a Medicare demonstration or that have other special processing rules. For example, the providers participating in the post-acute care demonstration project received a special exemption from RAC audits for the duration of their participation in the demonstration program. Once the demonstration program is over, claims will once again be subject to review. At this time, no other demonstration program has received a special exemption.
- Prepayment review. A RAC only may review Medicare payments using the post-payment claims review process. In addition, if the claim were subject to prepayment review at the time of original payment, it would be excluded from the claims available for review by the RACs.
- Claims that already have been reviewed by another contractor, as described below. Claims previously reviewed by any contractor for any reason are off-limits to the RACs. However, RAC review DOES NOT preclude later fraud investigation by various Medicare contractors, including program safety contractors (now Zone Program Integrity Contractors, or ZPICs) or the Office of Inspector General (OIG).

May a RAC review claims that are under review by another Medicare contractor?

Before a RAC reviews a claim, CMS requires that it check the RAC Data Warehouse to determine whether the claim is permanently excluded from RAC review because of prior review by another Medicare contractor. This warehouse will be updated on a regular basis by several Medicare contractors to ensure that the RACs are not duplicating reviews.

“Excluded” claims are claims that have already been reviewed by another entity such as the Medicare contractor (FI, quality improvement organization (QIO), carrier or other

primary claims processor), program safeguard contractor (e.g., ZPICs) or law enforcement. This includes claims that already have undergone a post-payment review, claims that were subjected to complex pre-payment review and claims that were originally denied and then paid on appeal. Exclusions are permanent.

CMS also prohibits RACs from reviewing claims that are being reviewed for potential fraud by CMS, the OIG, the Department of Justice or any other law enforcement entity. These providers and/or claims are referred to as being “suppressed” and will be included on the master table that a RAC must check prior to beginning review. This status is usually only temporary, and providers or claims with suppressed status will, in many cases, be released from this status once the investigation is completed. Once released, the RAC may review that claim. Alternatively, claims initially may be suppressed and then later permanently excluded depending on the outcome of a particular review.

For more information on the RAC Data Warehouse, please refer to CMS Transmittal CR 6273 issued on January 9, 2009.

If a provider performs a self audit, how should it notify the RAC?

If a provider identifies improper payments, the provider should report the improper payments to the Medicare program. There are specific legal requirements to be fulfilled under the auspices of self disclosure. Involve your legal counsel early in the self disclosure process. The exact information necessary for self disclosure can be determined by contacting your Medicare claims processing contractor (e.g., FI, carrier or MAC). If the claims processing contractor agrees that the prior claim(s) was paid improperly, the claim(s) will be adjusted and excluded from RAC review in the RAC Data Warehouse.

How many years of claims is a RAC permitted to review?

A RAC may not identify overpayments or underpayments that are more than three years past the date that the claim was originally paid. But in no case may a claim paid prior to October 1, 2007 be reviewed by a RAC. In other words, a RAC only will look at claims paid in federal fiscal year 2008 and forward. This policy will apply to all states, including the five demonstration states.

What is the RAC “new issue review” process?

The demonstration program was criticized for CMS’ lack of oversight in reviewing what claims the RACs targeted for review, how those reviews were conducted and what criteria were used in making determinations of improper payments. In response to those criticisms, and in an effort to make the permanent program more transparent, CMS has created a New Issue Review Board – the first program integrity board of its kind.

The New Issue Review Board is made up of several members of the CMS staff and its contractors, including CMS RAC project officers, the RAC validation contractor, the appropriate MAC/FI/carrier, the Center for Medicare Management and others. The

purpose of this board is to review and approve every issue – issues that may result in either overpayments or underpayments – that will undergo RAC review.

CMS has indicated that the composition of the board will change as needed to ensure appropriate subject matter experts are included in the review of each topic under consideration. Currently, there is no external representation on the board. The board will determine whether or not an audit will be approved based on the evidence of improper payments presented by each RAC. Evidence may include but is not limited to data analysis or documentation in medical records that indicates a prevalence of a particular type of error that warrants a widespread audit. In addition, the findings of a sample audit must be supported by Medicare policy including but not limited to the findings from the OIG, QIO reports, the national Medicare program manual, and national or local coverage determination (LCD) documentation.

Moreover, the RACs must describe the methodology for how they will target claims for review, and fully discuss the clinical criteria and processes by which they will make a determination of whether or not an improper payment was made. RACs may cite any literature, current medical practice or evidence-based guidelines, coding clinic reference materials or other documentation that would provide CMS with a full understanding of how the claims will be reviewed and a determination rendered.

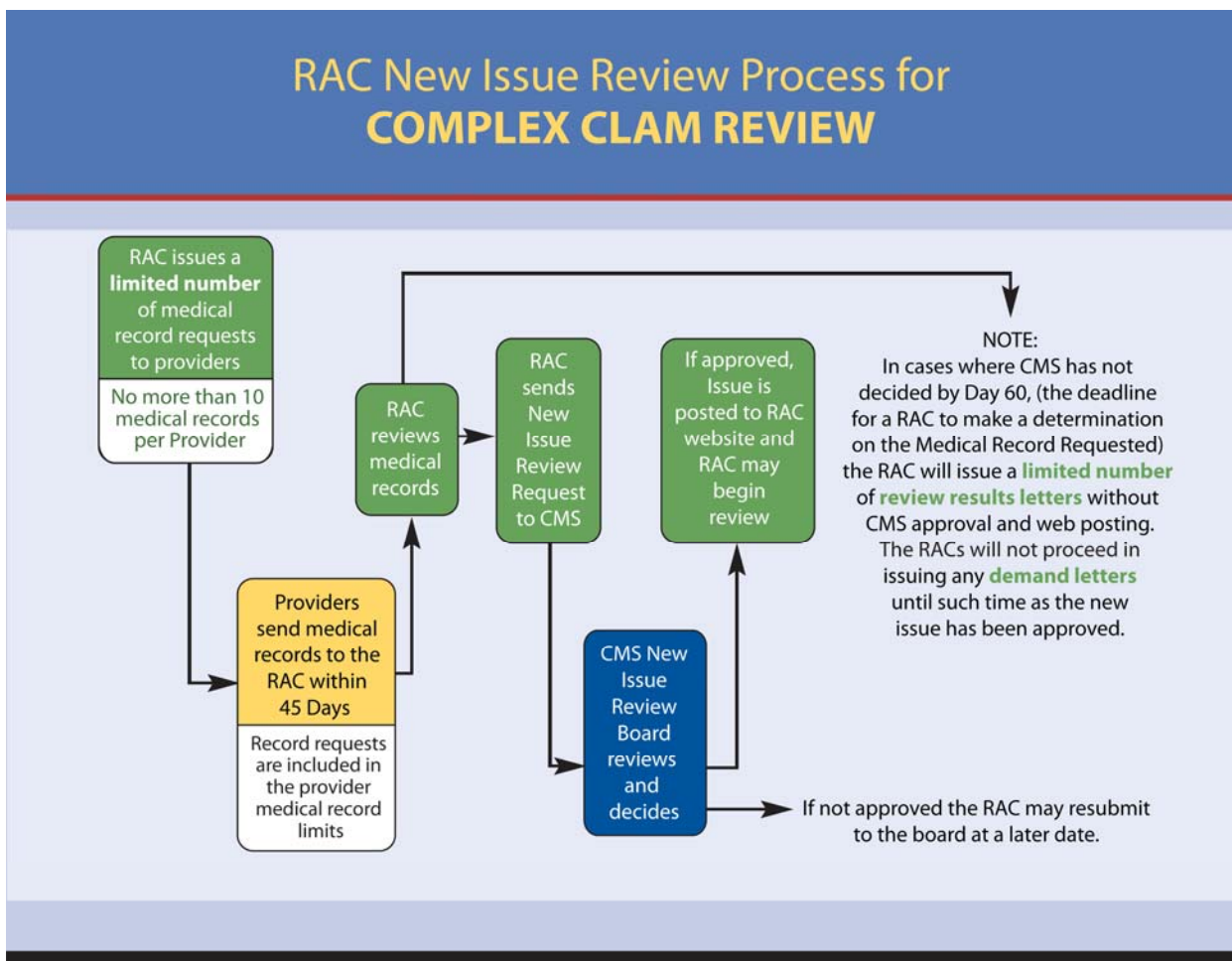
Any issue approved by the new issue review board for wide-scale audit by the RAC, will be posted to the RAC's Web site for public viewing in advance of any audit activity. If the RAC does not receive approval to proceed, it can resubmit that issue for review at a later date. Each RAC must propose its own claim targets, supported by its own evidence and review methods. Each issue is approved on a case-by-case basis and on a per RAC basis.

Providers are encouraged to monitor all RAC Web sites for information about the areas that may be targeted for audit. In addition, after audits of the new issues begin, if the RACs do identify a pattern of errors or "vulnerability," they will notify providers via their Web sites. CMS has set minimum thresholds for the RACs to trigger a "vulnerability" to be placed on its site. CMS has indicated that it will share information from the new issue review process and the vulnerabilities identified with the claims processing contractors for purposes of provider education or where applicable corrective action plans should be put in place.

Should I expect to see any communications from my RAC on an issue that has not yet been approved and posted to the RAC's Web site?

As noted above, CMS requires a RAC to present data analysis or other evidence of improper payments before it proceeds in wide-scale review of claims. In order for the RAC to compile that information, CMS will allow each RAC to request a limited number of medical records from hospitals before the new issue has been approved. CMS has indicated that no more than 10 medical records per provider can be requested for any particular issue before it has been approved by the New Issue Review Board.

When a RAC requests a medical record from a provider, it must render a determination within 60 days of receipt of that medical record. It is possible that the RAC may render a finding on their review of the medical record prior to CMS' approval of that particular issue in order to be compliant with the guidelines outlined by CMS for timely review of a medical record. However, CMS has noted that, while a determination may be found unfavorable for the provider by day 60, if the new issue has not been approved by CMS, the RAC cannot proceed in recoupment or refund of an improper payment. Providers should not receive a demand letter or an underpayment notification letter unless the new issue has been approved by CMS and posted to the RAC's Web site.



How long will it take for CMS to complete its review of each new issue presented by the RAC?

There is no timeline for CMS to process each new issue it reviews. The complexity of the issue presented to the board will determine the nature and extent of the expertise needed in order to approve the matter moving forward for broad-scale audit. Providers should expect that simple errors like duplicate payments that may be detected via an automated review would likely be promptly approved by CMS for widespread audit. However, more medically complex cases may warrant further consideration by the board and take additional time to move through the approval process.

Will RACs use a product like Interqual, Milliman or another screening tool to determine whether a claim should be denied? Will RACs tell providers which tool they will use?

A RAC cannot deny a claim just because it fails to meet Interqual or any other screening tool criteria. Nor should a provider assume that just because a claim passes Interqual or any other kind of screening tool that the service is covered by Medicare. If the RAC so chooses to utilize one of these publicly available products, that information will be shared with providers during the educational and outreach sessions. For more information, contact the RACs directly.

What is the difference between an ‘automated review’ and a ‘complex review’?

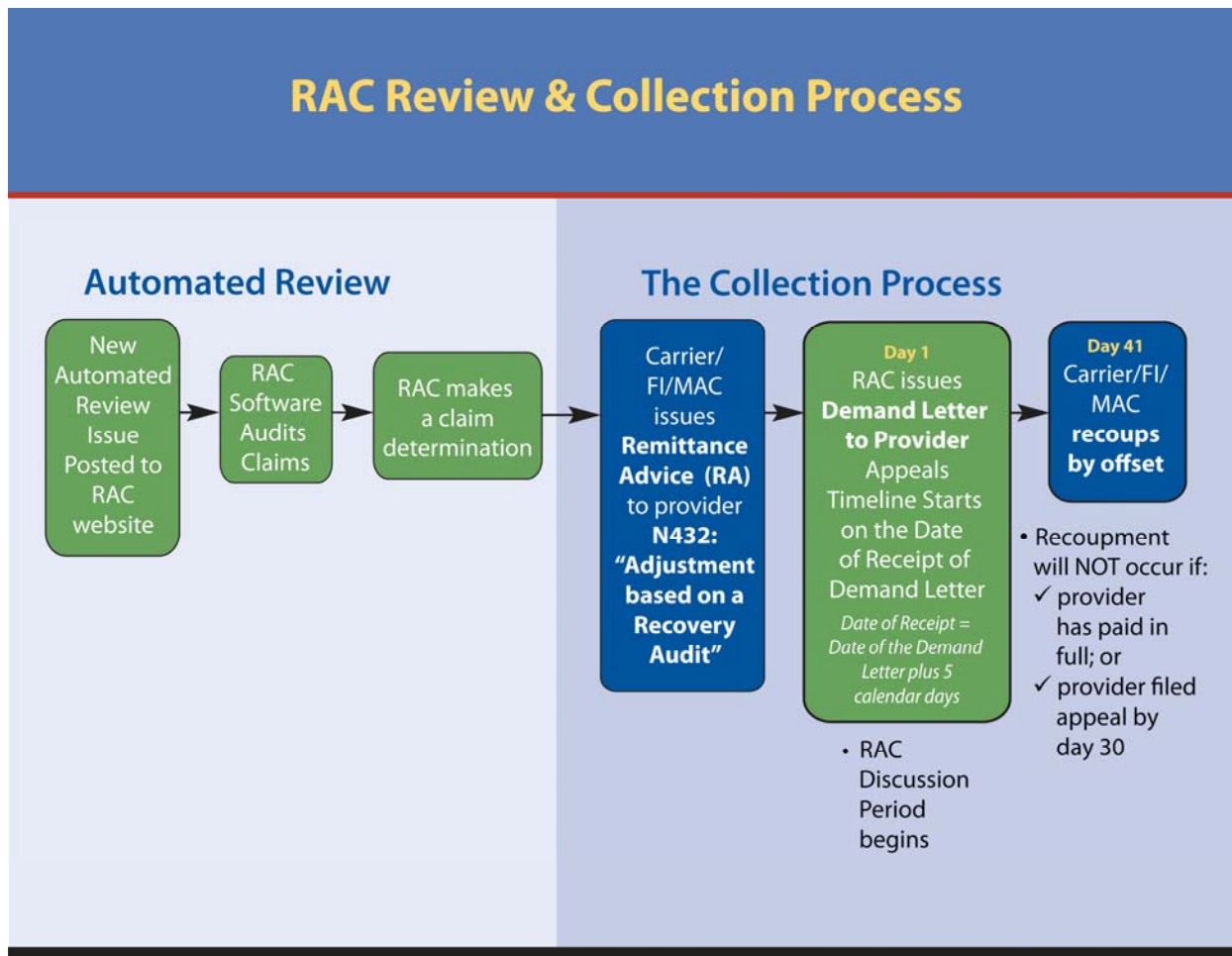
RACs identify overpayments and underpayments in two ways: automated review and complex review.

Automated review occurs when a RAC makes a claim determination *without a human review of the medical record*. Instead, the RAC uses proprietary software designed to detect certain types of errors. In order to make a coverage or coding denial using automated review, both of the following conditions must apply. First, there must be certainty that the service is not covered or is coded incorrectly. Second, there must be a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline supporting the determination. For example, an automated review could identify when a provider is billing for more units than allowed on one day.

The one exception to these conditions is for “clinically unbelievable” issues. In these cases, while there may be certainty that a service is not covered or is incorrectly coded, there may not be any written Medicare policy/articles/guidelines on the issue. In such cases, and as noted above, the RAC is required to seek approval from CMS in order to proceed on every issue for which it wishes to conduct an automated review.

The RAC may use automated review when making other types of administrative determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an underpayment or overpayment exists, even if written policies do not exist.

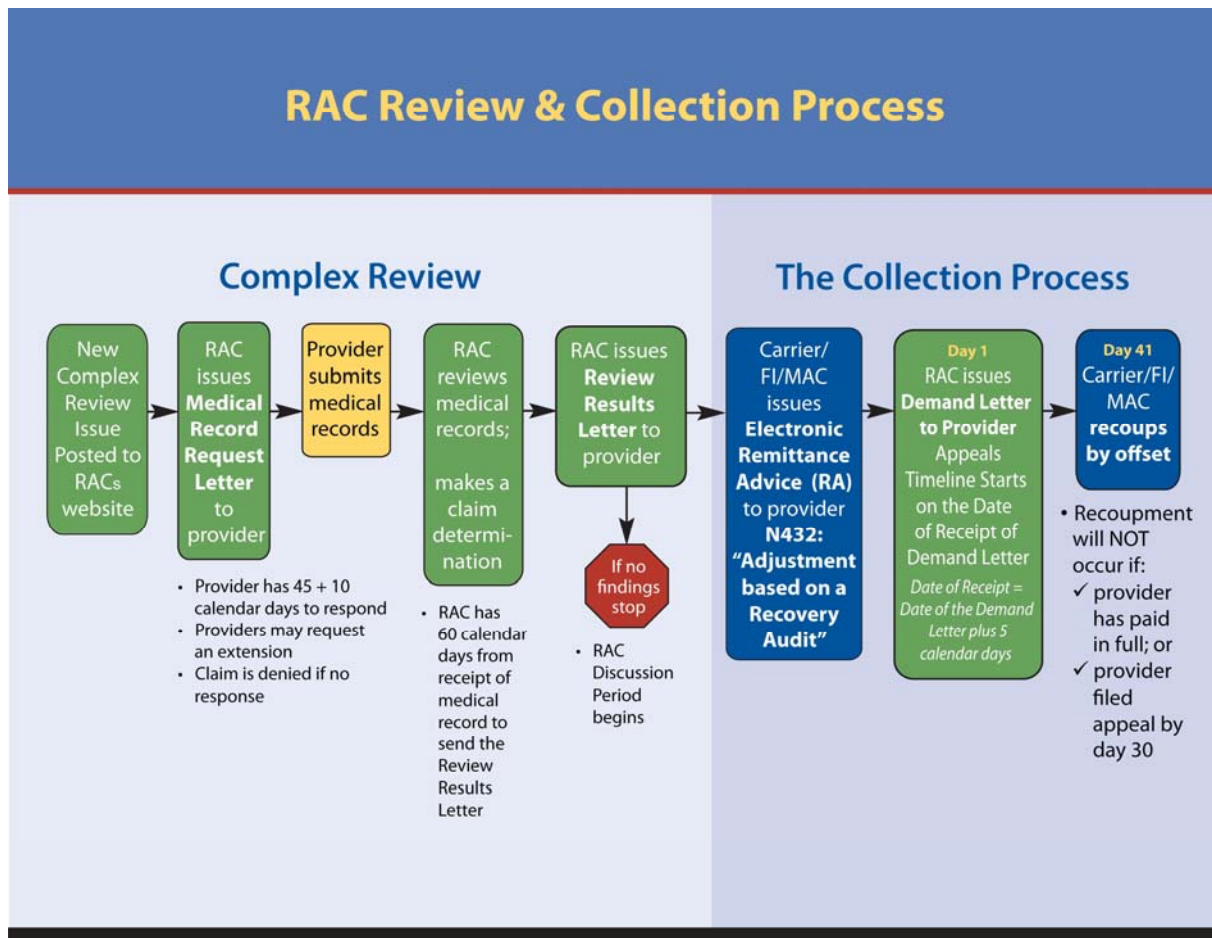
The chart below outlines the automated claim review and collection process.



Complex review occurs when a RAC makes a claim determination *using human review of the medical record*. Complex review is used when there is a high probability (but not certainty) that a service is not covered, or where no Medicare policy, guidance or Medicare-sanctioned coding guideline exists. In complex reviews, the RAC will need to review the medical record to determine whether or not a payment error occurred. Most complex reviews are medical necessity audits that assess whether care provided was medically necessary and provided in the appropriate setting.

Complex reviews *for which no written Medicare policy/articles/coding guidelines exist* are referred to as "individual claims determinations." In these reviews, the RAC must use appropriate medical literature and apply appropriate clinical judgment. The RAC's contractor medical director (CMD) must actively examine the evidence used in making individual claims determinations where the Medicare guidelines or literature are unclear.

The chart below outlines the RAC complex claim review and collection process. The notification and recoupment process is discussed later in this advisory.



How long does a provider have to submit a requested medical record?

A RAC must receive a requested medical record from a provider within 45 calendar days of the **date of the medical record request letter**. CMS has added an additional 10 calendar days (five days for the RAC and five days for the provider) to account for the U.S. mail delivery time. If the provider does not respond in the required timeframe, the RAC may determine the claim was found to be improperly paid and proceed with recoupment. However, under the permanent program guidelines, the RAC is required to initiate one additional contact with the provider prior to denying the claim for failure to submit documentation.

Does a provider have the right to request the status of medical records submitted to the RAC for complex review?

CMS requires a RAC to make information about the status of medical records (i.e., outstanding, received, review underway, review complete, case closed) available to providers upon request. Providers are encouraged to utilize the toll-free numbers set up by the RACs to verify the status of any issue. CMS is requiring all RACs, by January 1, 2010, to develop a Web-based application that will be used for this purpose. Providers

also will be able to use this Web-based application to customize their addresses and points of contact for RAC correspondence. It is expected that some RACs will have their Web-based applications up and running prior to January 1, 2010. Implementation of the Web-based application is contingent upon approval by CMS.

How long does a RAC have to complete a complex review of a medical record?

A RAC must complete a complex review within 60 calendar days from receipt of the medical record from the provider. A RAC may request a waiver from CMS if an extended timeframe is needed due to extenuating circumstances. If an extension is granted, the RAC is required to notify the provider of the situation that has resulted in the delay in writing or via a Web-based application.

What kinds of determinations may a RAC make when reviewing claims?

When a RAC reviews a claim, it may make any or all of the following determinations:

- Coverage Determinations. A RAC may find that a partial or full overpayment exists if the service is not covered. To be covered by Medicare, a service must be included in one of the statutory benefit categories, not be excluded from coverage, and be “reasonable and necessary.” A reasonable and necessary service is one that is safe and effective, not experimental or investigational, and appropriate (including duration and frequency).
- Coding Determinations. A RAC may find that a full or partial overpayment or underpayment exists if the service is coded incorrectly. This includes codes that fail to meet one or more of the coding requirements listed in a national coverage decision (NCD), local coding article, Coding Clinic, and the American Medical Association’s Current Procedural Terminology (CPT) or CPT Assistant.
- Other Determinations. A RAC may determine that a full or partial overpayment or underpayment exists if the claim was paid twice (i.e., a “duplicate claim”), was priced incorrectly, or the claims processing contractor did not apply a required payment policy (e.g., reducing payment by 50 percent for a second surgery).

RACs are not permitted to make denials for minor omissions such as missing dates or signatures.

With which national and local Medicare policies and articles must a RAC comply?

A RAC must comply with all national coverage determinations, coverage provisions in interpretive manuals, national coverage and coding articles, local coverage determinations (LCDs), local coverage/coding articles in its jurisdiction, and all relevant joint signature memos forwarded by CMS. A RAC is not permitted to apply an LCD retroactively to claims processed prior to the effective date of the policy. That is, the policies used in making a review determination must have been applicable at the time the provider rendered the service in question, except in cases of a retroactively liberalized LCD or CMS national policy.

What types of RAC staff are involved in performing complex reviews?

CMS requires that, for a complex review, coverage and medical necessity determinations are to be made by registered nurses or therapists and coding determinations are to be made by certified coders. If requested by the provider, a RAC must supply information about the credentials of the individuals making the review determinations. A RAC also must make its medical director available to discuss a claim denial at a provider's request.

Is a RAC required to employ a physician medical director?

CMS requires that each RAC employ a minimum of one full-time equivalent (FTE) contracted medical director (CMD), who must be either a doctor of medicine or a doctor of osteopathy and have relevant work and educational experience. More than one individual's time cannot be combined to meet the one-FTE minimum.

How is the overpayment amount determined?

A "full denial" occurs when a RAC determines that no service was provided or that the service the provider submitted was not reasonable and necessary and no other service would have been reasonable and necessary. In these instances, the overpayment amount is equal to the total amount the provider was paid for the service.

A "partial denial" occurs when a RAC determines that, while the level of service submitted by the provider was incorrect (i.e., not reasonable and necessary, upcoded or incorrectly coded), a lower level of service or a different service was provided. A partial denial also can occur if the Medicare primary claims contractor failed to apply a payment rule, thus causing an improper payment; for example, an FI failing to reduce payment on multiple surgical procedures provided during the same encounter.

For partial denials, a RAC must determine the level of service that was reasonable and necessary or represents the correct code for the service described in the medical record. The actual overpayment amount is determined when the claim processing contractor completes a claim adjustment and notifies the RAC of the amount to be recovered. A RAC can only collect the difference between the paid amount and the amount that should have been paid.

Once an overpayment is identified, a RAC is required to proceed with the recovery of the Medicare overpayment.

If an overpayment is identified by a RAC, is the provider also responsible for returning the amount collected from the patient or the secondary payer when an inappropriate overpayment is identified?

Yes. The provider participation agreement notes that providers must repay the patient and any secondary insurer when appropriate.

Will extrapolation of claims be allowed by the permanent RAC contractor?

A RAC may use extrapolation, but only in situations where there is a sustained or high level of payment error or documentation that the carrier/FI/MAC educational interventions have failed to correct the payment error. If a RAC does propose to use

extrapolation, that methodology will undergo new issue review and approval before proceeding. Information on what process and methodology the RACs must use for extrapolation can be found in section 3.10 of the *Medicare Program Integrity Manual*.

Will a RAC receive a full contingency fee for claims in which it utilizes the extrapolation procedure outlined in the statement of work?

Yes. A RAC will receive its full contingency fee for extrapolated claims.

If a provider has performed a self-audit prior to RAC review and wants to extrapolate the findings, will all the claims included in a self-audit be excluded from RAC review?

If a provider self-discloses a payment error and the claims processing contractor confirms that a payment error exists and the sampling/extrapolation methodology used is correct, then these claims will not be reviewed by the RAC. The claims processing contractor will exclude the self-disclosed claims in the RAC data warehouse.

How will RACs communicate the result of an automated claim review to a provider?

A RAC is required to communicate to a provider the results of each automated review that results in an overpayment determination, including the coverage/coding/payment policy or article that was violated.

In the case of an automated review that results in an overpayment, the provider will receive a **demand letter** that communicates the finding of an overpayment. This letter may contain a list of claims denied for the same reason. The provider will not know that the RAC is looking at a particular claim until such time as a demand letter is sent, as no medical record was requested. However, a provider will know that the issue was approved for wide-scale automated review by CMS because it will be posted on the RAC's Web site.

The demand letter will come directly from the RAC and will contain the following information:

- The amount of the denial;
- The method for calculating the denial;
- The reason the original payment was incorrect;
- The regulatory and statutory basis for the denial;
- The providers' option to submit a rebuttal statement (described in the AHA Medicare Appeals advisory available at <http://www.aha.org/aha/advisory/2009/090327-regulatory-adv.pdf>);
- The providers' appeal rights, which are separate from the rebuttal process; and
- The recoupment, payment and interest options for the provider and the associated timelines.

CMS currently is updating and reviewing the language for the RAC demand letters. When the letters are finalized, CMS has indicated that it will share them with the AHA. We will make these letters available on our Web site.

How will a RAC communicate the result of a complex claim review to a provider?

A RAC is required to communicate to a provider the results of each complex review that identifies an overpayment determination, including the coverage/coding/payment policy or article that was violated. The RAC also must inform the provider of cases where no improper payment was identified.

For complex reviews **where an overpayment has NOT been identified**, the provider will be notified of the non-finding in a **review results letter**. If no overpayment is found, there will be no further action on this claim. This concludes the review by the RAC for that particular claim.

For complex reviews **where an overpayment has been identified**, there will be TWO communications from the RAC. The first is the review results letter, which, issued on a per claim basis, notifies the provider of the overpayment. The second is the demand letter, noted below.

For complex reviews, regardless of the finding, the RAC must send a review results letter to the provider within 60 calendar days of receipt of medical records (or left within 60 days of the exit conference, required to be conducted at the end of provider on-site reviews) unless CMS grants an extension.

The review results letter must include:

- Identification of the provider;
- The reason for conducting the review;
- A narrative description of the improper payment (if identified) stating the specific issues involved that created the improper payment and any pertinent issues; and
- The findings for the claim including a specific explanation of why any services were determined to be non-covered or incorrectly coded, etc.

CMS has worked to standardize all review results letters to be issued by the RACs. These letters are still under review at CMS. When they become available, the AHA will post these letters to its Web site.

Subsequent to the review results letter that notifies the provider that an overpayment has been identified as part of the complex review, the RAC will send a follow-up **demand letter** to the provider. The time between the review results letter and the demand letter may be only a matter of days. Eventually, CMS hopes that the review results letter and demand letter will be one communication. However, due to the need for communication between the RAC and the Medicare claims processing contractor, the communications will be separate. The demand letter will come directly from the RAC and will contain the following information:

- The amount of the denial;
- The method for calculating the denial;
- The provider's option to submit a rebuttal statement (described in the AHA Medicare Appeals advisory available at <http://www.aha.org/aha/advisory/2009/090327-regulatory-adv.pdf>);
- The provider's appeal rights, which are separate from the rebuttal process; and
- The recoupment, payment and interest options for the provider and the associated timelines.

What is the RAC remark code N432?

At the same time that a written demand letter is being sent to the provider via U.S. mail, the provider will be issued a remittance advice indicating a pending recoupment with the RAC Remark Code "N432."

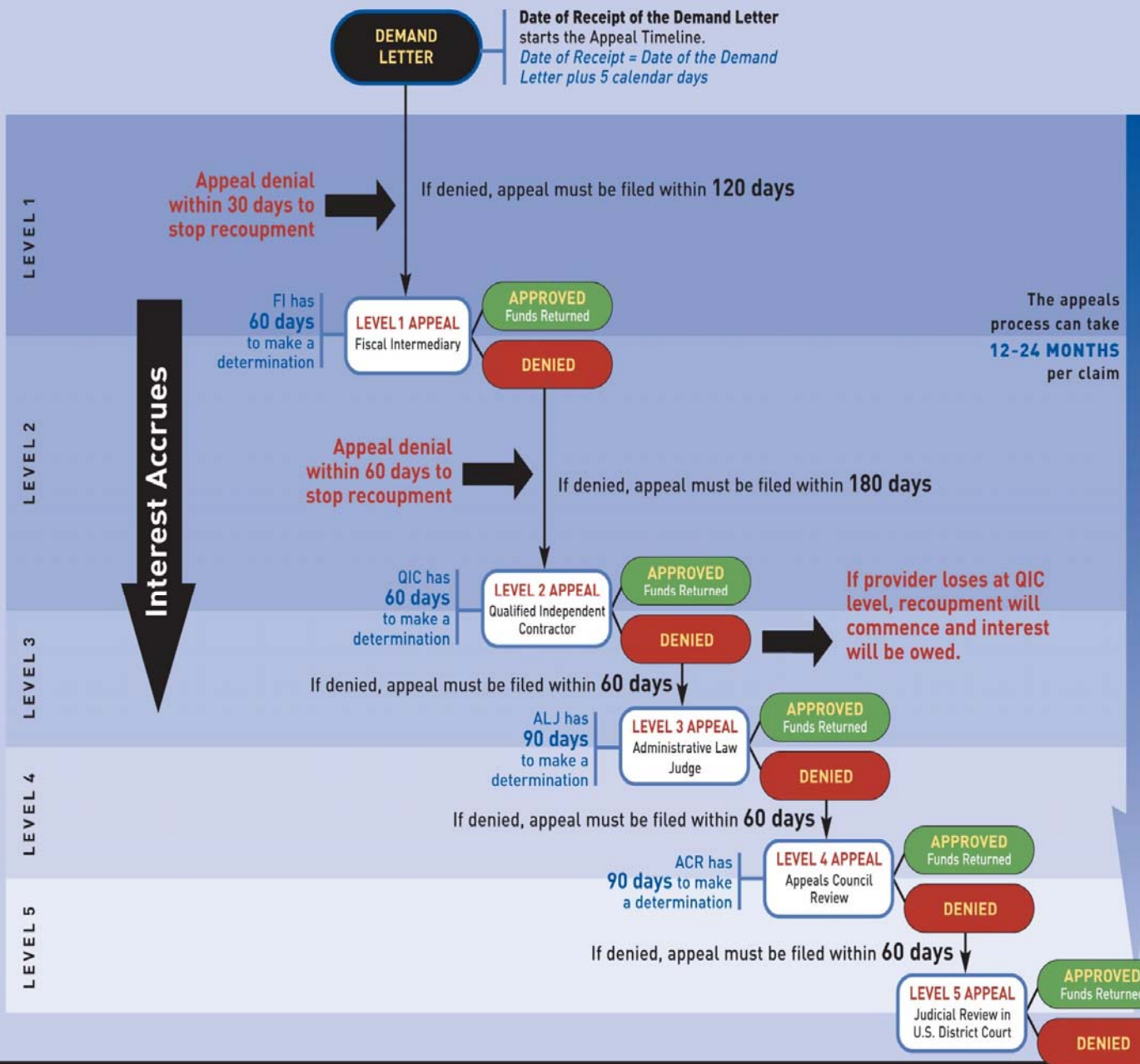
When does the clock start for a level one appeal to be filed?

The clock for a Level 1 appeal to the claims processing contractor begins on the date of receipt of the demand letter from the RAC. Per federal regulations, CMS considers the date of the receipt to be five calendar days from the date of the demand letter.

A flow chart outlining the Medicare Appeals Process follows on the next page.

For more information on the Medicare Appeals process, please review AHA's Medicare Appeals advisory at <http://www.aha.org/aha/advisory/2009/090327-regulatory-adv.pdf>.

MEDICARE APPEALS PROCESS



What is the RAC ‘discussion period’?

Each RAC will offer a 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. For example, if the claim was denied due to missing documentation in the medical record that would have justified the services rendered, the provider may submit that information to the RAC. In addition, the discussion period may be used by the provider to further discuss the finding with the RAC.

- The discussion period is NOT part of the formal Medicare Appeals process.
- Engaging in the discussion period does NOT necessarily preclude recoupment by the RAC for an overpayment it has identified. Only qualifying formal appeals may postpone recoupment.
- The discussion period starts at different times depending on whether or not the review was automated or complex.

For automated reviews, the discussion period begins with the notification of an overpayment via the **demand letter** from the RAC.

- To discuss the matter further, CMS advises the provider to contact the RAC within 15 calendar days of the date of the demand letter.
- 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 FI/MAC at the same time it is discussing the matter with the RAC.

For complex reviews, the discussion period begins with the notification of an overpayment via the **review results letter** from the RAC.

- CMS advises the provider to contact the RAC within 15 calendar days of the date of the review results letter.
- 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 that demand plus five calendar days will start the timeline for a Medicare appeal.

If a hospital receives a demand letter from a RAC because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can all the services be re-billed on an outpatient claim?

Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the *Medicare Benefit Policy Manual*. That list can be found in Chapter 6, Section 10 at <http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf>.

Re-billing for any service will *only* be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the permanent RAC program as there were in the demonstration program. The time limit for re-billing claims

is 15-27 months from the date of service. These normal timely filing rules can be found in the *Claims Processing Manual*, Chapter 1, Section 70 at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.

How will a RAC obtain copies of medical records for review?

A RAC is permitted to obtain copies of medical records by going on-site to the provider's location to view and copy the records, or by requesting that the provider mail, fax or otherwise securely transmit the records to the RAC.

Providers may refuse to allow a RAC on-site access to their facilities. In these circumstances, the RAC is prohibited from making an overpayment determination based upon the lack of access. Instead, the RAC would need to request copies of the records in writing. When an on-site review results in an improper payment finding, the RAC will copy the relevant portions of the medical record and retain them for future use.

All medical record request letters must adequately describe a RAC's good cause for reopening claims that were paid more than one year from the date of the medical record request letter. CMS clarifies that good cause may include, but is not limited to, OIG report findings, data analysis findings and comparative billing analysis. These findings and reports may highlight systematic and recurring errors that warrant closer review by the RAC and can justify reopening a claim. CMS has worked to standardize the Medical Record Request letters to be issued by the RACs. These letters are still under CMS review and, when available, AHA will post them to its Web site.

Can scanned images of medical records be submitted to a RAC?

Yes, providers can submit scanned images of medical records to the RAC for review. Providers who choose to send imaged medical records on CD or DVD must meet the requirements set forth by the RAC. These requirements are still in development and, when they become available, AHA will share them broadly. Until such time as they are available, providers should contact their RAC for more information.

Will a RAC be required to pay for copies of the medical records it requests?

A RAC is required to pay only for copies of medical records associated with acute-care inpatient prospective payment system (PPS) hospital diagnosis-related group (DRG) claims and long-term care hospital claims. For these records, the RAC must pay the provider for producing the records according to the current formula or any applicable payment formula created by state law. The current rate for medical records photocopying is 12¢ per page for inpatient PPS provider records plus first class postage. Providers, such as critical access hospitals, that are paid under a Medicare cost reimbursement system receive no photocopying reimbursement but can include RAC-related coping expenses in their cost reports.

A RAC is required to pay on at least a monthly basis for copying of inpatient PPS and long-term care hospital medical records. CMS requires that all checks to the provider for medical record copies be issued within 45 days of receiving the medical record.

As noted above, CMS requires RACs to accept imaged medical records sent on CD or

DVD beginning immediately, as well as imaged records sent electronically starting in 2010. However, RACs must remain capable of accepting faxed or paper medical records indefinitely. RACs will pay the same per-page rate for imaged or electronic medical records as for printed or faxed images.

For claims other than acute-care inpatient PPS and long-term care hospital claims, RACs may, but are not required to, pay for medical records using any formula a RAC desires. For more information about how the RACs will implement this policy, please contact your RAC directly.

Are there limits to the number of records a RAC may request?

CMS recently posted its medical record request limit policy on its Web site but notes that the limit is still undergoing further refinement. The policy limits the number of medical records that can be requested for each service type (inpatient, outpatient, etc.), taking into consideration Medicare volume for that service and number of national provider identifiers (NPIs) per provider. The record limits noted below apply to the number of medical records that can be requested in a 45 calendar day period.

A summary of the CMS policy, as well as questions posed by AHA and CMS' answers regarding how this policy will be implemented, can be found in Attachment A.

Can a RAC increase the number of records requested if it does not request records in the prior 45 day period?

No. CMS notes that a RAC may not supersede the medical record request limit by "bunching" medical record requests. For example, if the medical record request limit for a particular provider is 50 per 45 days and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

How will providers be notified of the medical record request limit for their organization?

CMS has indicated that the RACs will develop the medical record request limit for each organization and communicate it to the provider in the initial medical record request letter. If a provider believes that there has been an error in the calculation, it should first proceed in contacting the customer service line for their RAC and then if not resolved, proceed in contacting its RAC project officer at CMS headquarters.

How will RACs identify and process underpayments?

A RAC will review claims using automated or complex reviews to identify potential Medicare underpayments. For purposes of the RAC program, a Medicare underpayment is defined as those lines or payment groups on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group creates an underpayment, and those changes are supported by documentation in the medical record, the RAC will identify an underpayment. Service lines or payment groups that a provider failed to include on a claim are not considered underpayments for the purposes of the program.

Upon identification of the underpayment, a RAC will communicate the underpayment finding to the appropriate Medicare FI, carrier or other contractor. The claims processing contractor will validate the Medicare underpayment, adjust the claim and pay the provider. The RAC then will issue a written underpayment notification letter to the provider outlining claim and beneficiary detail. In addition, notification of an underpayment could also be found upon completion of a complex review. A subsequent review results letter may also communicate such findings to then be followed by the notification letter.

A RAC is not required to accept unsolicited case files from providers for an underpayment case review. However, RACs may request medical records for the sole purpose of identifying an underpayment. The same requirements to pay for copies of requested medical records apply to RACs regardless of whether an underpayment or overpayment is determined.

NEXT STEPS

Hospitals strive for payment accuracy and are committed to continuing to work with CMS and its contractors to ensure the validity of hospital payments. However, the AHA has concerns about the RAC program and believes that the program, as currently designed, needs improvement. We will continue to encourage CMS and Congress to make additional changes and formalize several incomplete implementation policies before any further RAC activities take place. Please visit www.aha.org/rac for additional AHA member resources and an updated list of upcoming educational events.

FURTHER QUESTIONS

Please contact Alyssa Keefe or Rochelle Archuleta at (202) 638-1100 or e-mail RACinfo@aha.org.

CMS Recovery Audit Contractor Medical Record Request Limit Policy
www.cms.hhs.gov/rac

CMS Policy

For ALL Inpatient Hospital, Inpatient Rehabilitation (IRF), Skilled Nursing (SNF), Long-Term Care Hospitals, Psychiatric Hospitals and Hospice Providers by National Provider Identifier (NPI)

10% of average monthly Medicare paid claims
 Maximum of 200 records per 45 days per NPI

For ALL Hospital Outpatient, Home Health, by NPI

1% of average monthly Medicare paid services per 45 days
 Maximum of 200 medical records per 45 days per NPI

The above formula is applied in the following way to both Medicare paid claims and services for hospitals:

CMS Example 1: Local Community Hospital

1,200 Medicare Inpatient paid claims in fiscal year 2007*

Divided by 12 = average 100 Medicare paid claims per month

x 10% = 10

Limit = 10 medical records per 45 days

*All record limits are based on federal fiscal year 2007 volume.

AHA Example #1: Hospital A with 1 National Provider Identifier (NPI)

10% of average monthly Inpatient (IP) claims	25
1% of average monthly Outpatient (OP) services	75
10% of average monthly Inpatient Rehabilitation (IRF) claims	<u>25</u>
	125
<u>TOTAL medical record request limit per 45 days</u>	<u>125</u>

Hospital A Questions:

1. Will the limits for each of the service areas under the single NPI be added together to determine the overall medical record request limit, as shown?
 Answer: YES
2. How will the record requests for each service be applied?
 Answer: No more than 25 IP claims, 75 OP claims or 25 IRF claims can be pulled in any 45 day period. A RAC cannot request 125 IP claims and be within the medical records limit.

AHA Example #2: Hospital B with 1 NPI

10% of average monthly IP claims	125
1% of average monthly OP services	175
10% of average monthly IRF claims	<u>50</u>
	350

TOTAL medical record request limit per 45 days *Maximum* 200

Hospital B Question:

1. Can the RAC request for medical records exceed the individual service limits?

Answer: No. The RAC's medical record request limit for Hospital B is 200 and the number of records requested for each service cannot exceed its individual service limit. So for example, in one 45 day period a RAC could request 175 outpatient records but then only have 25 additional records in which it could request from another service area. Alternatively, a RAC could request 50 rehabilitation claims and then 125 inpatient claims and the remainder outpatient claims as long as the service limit and the overall 200 limit is honored.

AHA Example #3: Hospital C with 5 NPIs

Some hospitals have added NPIs for distinct part units. Hospital C has chosen 5 NPIs for each of its services

10% of average monthly Inpatient claims	100
1% of average monthly Outpatient services	175
10% of average monthly Skilled Nursing (SNF) claims	25
10% of average monthly Home Health (HH) services	25
10% of average monthly IRF claims	<u>50</u>
	375

TOTAL record request limit per 45 days *Maximum* 200.

Hospital C Questions:

1. How will CMS apply the medical request limit if I have more than 1 NPI?
Answer: CMS has noted that for a hospital campus with more than one NPI, the overall limit will still be capped at 200 medical records per 45 days. CMS has noted however, that it will be looking at organizations with multiple NPIs closely to ensure that the organizational structure of the hospital does indeed warrant a cap of 200 medical record requests. It is not CMS intent to have multi-hospital systems subject to a cap of 200 medical record requests per 45 days.

CMS Policy

Physicians by NPI

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

AHA Question:

1. If there is a group or large group practice and within that group each physician has his or her own NPI, will the RAC be required to use the NPI for the individual physician or will the requirement for them to use the group or large group NPI?

CMS Answer: CMS has clarified the RACs will use the group or large group NPI in establishing the medical record request limits rather than the individual physician NPI when appropriate to do so. For CMS to use that group or large group NPI, the claim must be submitted for processing using that number.

CMS Policy

Durable Medical Equipment (DME), Ambulance and Lab by NPI

1% of average monthly Medicare paid services per 45 days
Maximum of 200 medical records per 45 days per NPI

CMS Example:

1,500 Medicare paid services in 2007
Divided by 12 = avg 125 Medicare paid services per month
x 1% = 1.25

Limit = 2 records per 45 days

CMS Example:

360,000 Medicare paid services in 2007
Divided by 12 = avg 30,000 Medicare paid services per month
x 1% = 300

Limit = 200 records per 45 days (capped at the maximum of 200)