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Medicare Recovery Act Contractors (RAC) Overview¹

In March 2005, CMS (Centers for Medicare and Medicaid Services) launched the 3-year RAC demonstration in the states of California, Florida and New York. The RAC demonstration was later expanded to the states of Massachusetts, South Carolina and Arizona, and was ultimately completed in March 2008.

The demonstration discovered \$1.03 billion in Medicare improper payments at a cost of \$187.2 million, and returning \$693.6 million to the Medicare Trust Funds. Of the improper payments identified, 96 percent (or \$992.7 million) were overpayments and only 4 percent (or \$37.8 million) were underpayments repaid to providers.

Before the RAC demonstration was completed, Congress made the RAC program permanent when it enacted the Tax Relief and Health Care Act of 2006 (TRHCA). In fact, the TRHCA directs HHS to expand the RAC program to all 50 states by January 1, 2010. To accomplish this objective, CMS intends to implement the nationwide RAC program in phases beginning in March 2009. Therefore, Medicare providers should become informed about the RAC program and prepare for its implementation.

What is CMS's expansion schedule for the nationwide RAC program?

For purposes of the nationwide RAC program, CMS has divided the United States into [4 geographic regions](#). Except as described below, 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.

What improper payments will be subject to RAC review?

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?

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;

¹Source: <http://www.cms.hhs.gov>

- 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.

How will RACs identify overpayments and underpayments?

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?

Automated review will occur when a RAC makes a claim determination at the system level without human review of the medical record. RACs may use automated review when making coverage and coding determinations when:

- there is certainty that the service is not covered or is incorrectly coded; and
- a written Medicare policy, article or sanctioned coding guideline exists.

However, if a RAC identifies a "clinically unbelievable" issue (i.e., where certainty of noncoverage or incorrect coding exists but no Medicare policy, articles or sanctioned coding guideline exists), a RAC may seek CMS approval for automated review.

What is complex review?

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.

Will medical records be requested from providers for complex reviews?

Yes. However, CMS will impose medical record request limitations. CMS has released a [document](#) outlining the current medical record request limitations.

How long will providers have to respond to medical record requests?

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?

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. However, RACs are permitted (but not required) to pay for medical records associated with other types of claims.

What types of standards will CMS impose for complex reviews?

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?

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?

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?

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?

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

How will overpayments be recovered?

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.

Will interest accrue on overpayment determinations?

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?

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.

How can providers prepare for the RAC program's nationwide implementation?

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 organizational leadership, compliance committee and functions, and possible targeted service lines about the RAC program;
- Proactively audit or review perceived vulnerabilities and take corrective actions;
- Develop a plan and internal processes to respond to RAC medical record requests, reviews and determinations; and
- Know how to navigate the Medicare appeals process (and the possible arguments and defenses to RAC determinations).

The DRS *RACexpress*™ Solution

On top of ever increasing pressure to convert to electronic records and train physicians in computerized order entry, where will you find the resources to respond to RAC audit demands within the required timeframe?

DRS has the answer – the *RACexpress*! It's our painless answer for hospitals and medical clinics. We come to your facility and handle everything, from record scanning to indexing. You wind up with a CD or DVD containing the requested records and documents in an electronic format compatible with RAC requirements. DRS can also integrate these files into the RAC management software of your choice. And the best part is Medicare reimbursements could pay for the entire conversion service!

Visit our Website (www.drsimaging.com) to learn more about this easy, fast and certainly affordable means of responding to ongoing RAC audit requests in a timely fashion.

**For more information, call toll free (877) 924-8680 x111
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