

# Medicare Recovery Audit Contractor Program

What to expect and how to prepare.

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In December 2003, the Medicare Modernization Act of 2003 (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the Recovery Audit Contractor (RAC) program as a 3-year demonstration.

The RAC demonstration program began in March 2005 and involved California, Florida, and New York. In 2007, the program expanded to include Massachusetts and South Carolina before ending on March 27, 2008. Through the Tax Relief and Health Care Act of 2006, Congress mandated that the RAC program become permanent and nationwide as of January 1, 2010. The RAC permanent program has implemented changes based on lessons learned during the 3-year demonstration project (Table 1). Understanding a RAC's

review and collection process will lessen the impact that this program has on health care providers.

## BASIC RAC OVERVIEW

The goal of the RAC program is to identify improper payments made on claims of health care services provided to beneficiaries under Medicare parts A and B. Improper payments may be overpayments or underpayments. Overpayments can occur when health care providers submit claims that do not meet Medicare's policies for coding, coverage, or medical necessity. An example of an underpayment is when a health care provider submits a claim for a simple procedure but the medical record reveals that a

**TABLE 1. CHANGES BASED ON LESSONS LEARNED**

	Demonstration RACs	Permanent RACs
Look-back period (from claim's payment date to date of medical record request)	4 years	3 years
Maximum look-back date	None	October 1, 2007
Allowed to review claims in current fiscal year?	No	Yes
RAC medical director	Not required	Mandatory
Certified coders	Optional	Mandatory
Discussion with RAC medical director regarding claim denials if requested	Not required	Mandatory
Credentials of reviewers provided upon request	Not required	Mandatory
Vulnerability reporting	Limited	Mandatory
RAC must pay back the contingency fee if the claim overturned at ...	... first level of appeal	... all levels of appeal
Web-based application that allows providers to customize address and contact information	None	Mandatory by January 1, 2010
External validation process	Not required	Mandatory
Changes based on lessons learned during the 3-year demonstration are listed, along with a side-by-side comparison showing the differences between the demonstration project and the newly implemented permanent program.		

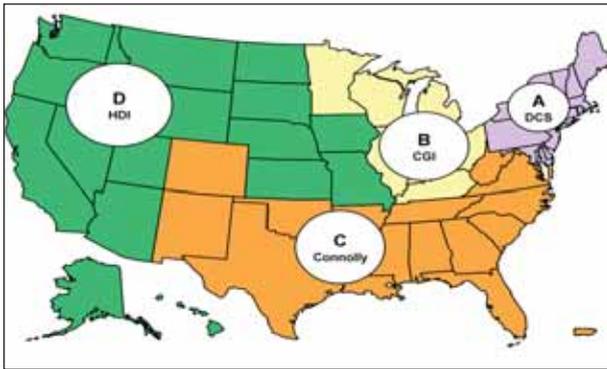


Figure 1. An overview of each of the four RAC regions and the RAC responsible for recovery activities in that region.

more complicated procedure was actually performed. Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, hospice agencies, durable medical equipment suppliers, and any other provider or supplier that bills Medicare fee-for-service claims to parts A and B. RACs review claims on a postpayment basis. They use the same Medicare policies as carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs).

The CMS have divided the United States into four regions, each having its own RAC. Each RAC is responsible for identifying overpayments and underpayments in approximately one-quarter of the country (Figure 1).

**PREPARING FOR RAC AUDITS**

Health care providers can prepare for RAC audits by monitoring prior improper payments and keeping track of all claims denied; looking for patterns of prior improper payments to determine what corrective actions need to occur to avoid future improper payments; monitoring their region’s RAC Web site for updates on approved new issues; and monitoring the status of their claim during the RAC review process by utilizing the RAC claim status Web site. Providers can also develop a plan of action for responding

to RAC additional documentation requests. This could involve developing a RAC team to coordinate all RAC activities.

Knowing where previous improper payments have been found is also helpful. The CMS suggest that health care providers identify what improper payments were found by the RACs during the 3-year demonstration and, if necessary, perform a self-audit. Improper payments that have been found by the Office of Inspector General can be seen at [www.oig.hhs.gov/reports.asp](http://www.oig.hhs.gov/reports.asp), and the Comprehensive Error Rate Testing Contractor can be reviewed at [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert).

**RAC REVIEW AND COLLECTION PROCESS**

If a RAC wishes to pursue an audit for a particular item or service to identify an improper payment, the RAC must submit its audit ideas (new issues) to the CMS for approval prior to any widespread review. The CMS require RACs to post all CMS-approved new issues on their respective RAC regional Web site prior to any widespread review of those issues. All providers are encouraged to monitor their respective RAC’s Web site for updated approved new issues. The CMS also requires each RAC to have a claim status Web site, to allow providers to track the status of the claim under review.

**Automated and Complex New Issues**

RACs can submit both automated and complex new issues to the CMS for approval (Figure 2). Automated new issues are those for which an improper payment can be made without reviewing medical records and/or additional documentation. The RAC may use automated reviews when making administrative determinations such as duplicate claims, pricing, and other coding errors. Complex new issues require medical records and/or additional documentation to determine whether an improper payment has occurred. Complex review is used when there is a high probability that a service is not covered under Medicare policies, as in the case of medical necessity audits.

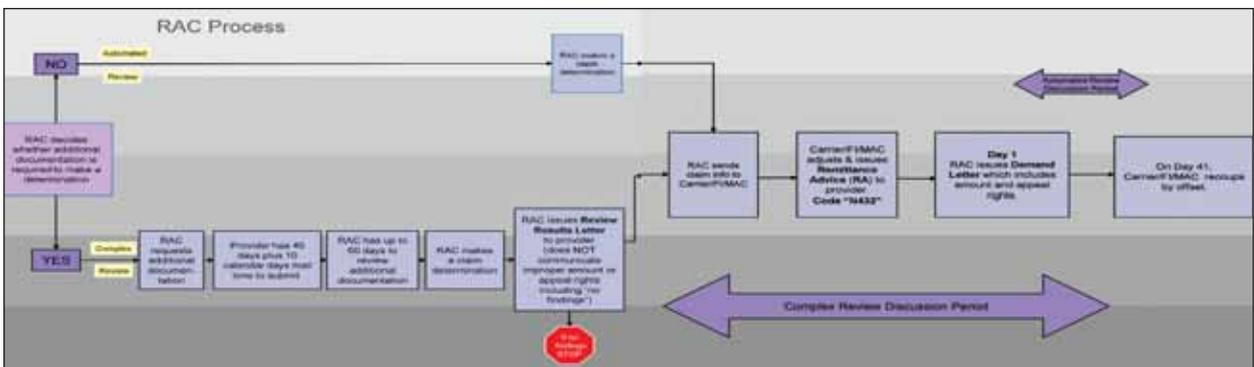


Figure 2. A graphic display of the RAC review process for both automated and complex reviews.

## CMS RECOVERY AUDIT CONTRACTORS

The following list identifies information unique to each of the four RACs.

### **RAC Region A: Diversified Collection Services, Inc. (DCS) of Livermore, California**

States in Region: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont

Subcontractors: PRGX Global, Inc., of Atlanta and iHealth Technologies, Inc., of Atlanta

E-mail: [info@dcsrac.com](mailto:info@dcsrac.com)

Web site: <http://www.dcsrac.com/portal.html>

### **RAC Region B: CGI Technologies and Solutions, Inc., of Fairfax, Virginia**

States in Region: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

Subcontractor: PRGX Global, Inc.

E-mail: [racb@cgi.com](mailto:racb@cgi.com)

Web site: <http://racb.cgi.com/>

### **RAC Region C: Connolly Consulting Associates, Inc., of Wilton, Connecticut**

States in Region: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, and West Virginia

Subcontractor: Viant Inc. of San Francisco

E-mail: [racinfo@connollyhealthcare.com](mailto:racinfo@connollyhealthcare.com)

Web site: [http://www.connollyhealthcare.com/RAC/pages/cms\\_RAC\\_Program.aspx](http://www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx)

### **RAC Region D: HealthDataInsights, Inc. (HDI), of Las Vegas**

States in Region: Arizona, Alaska, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming

Subcontractor: PRGX Global, Inc.

E-mail: [racinfo@emailhdi.com](mailto:racinfo@emailhdi.com)

Web site: <https://racinfo.healthdatainsights.com/>

## Improper Payments

RACs are tasked with identifying improper payments on a postpayment basis. Once an improper payment is identified, the RAC submits the claim file to the carrier, FI, or MAC. It is the responsibility of the carrier, FI, or MAC to adjust the claim. The carrier, FI, or MAC will then issue a

remittance advice with the remark code N432 (when possible). This code recognizes that the claim adjustment was based on a recovery audit review. The RAC is responsible for issuing the first demand letter.

## Appeal Process

The appeal process for RAC denials is the same process that is used for all other carrier, FI, or MAC claim denials. Additional information regarding the appeals process and timeframes for appealing a RAC claim determination can be found at <http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf>.

## Discussion Period

The RAC discussion period is a new process that is unique to the RAC program. The RAC discussion period allows providers the opportunity to contact their respective RAC to discuss review determinations and to submit additional evidence to the RAC that indicates why the claim should be paid as billed. The discussion period is separate from the formal Medicare appeals process.

## CONCLUSION

At this time, the CMS have completed provider outreach in all 50 states through in-person meetings, Webinars, and teleconferences. The CMS continue to provide extensive outreach to providers and provider associations. All RAC customer service call-in centers are operational, and all four RACs have established Web sites to provide valuable jurisdiction-specific information to the provider community. RACs have established joint operating agreements with the appropriate carrier, FI, or MAC in their respective jurisdictions. RACs have been given Medicare claims data to perform data analysis, and all states are now eligible for widespread review.

Providers are also encouraged to visit the CMS RAC Web site at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC) for updates on the RAC national program. On the Web site, health care providers can register to receive e-mail updates and view current RAC activities nationwide. Questions about the RAC national program can be submitted to the CMS by e-mailing [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov). ■

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