Recovery Audit Contractors: What it Means for Today's Radiologist

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With the ongoing strain from rising healthcare costs, the Medicare Trust Fund continues to be under pressure to deliver the same benefits to its recipients now and in the future. The US Treasury reports $514 billion spent on Medicare in 2010, a 467% increase since 1990. Through recent legislations, one of the key areas identified by Congress to control spending is a program to identify and recoup "improper" payments to Medicare providers, estimated by the Governmental Accountability Office (GAO) to be $48 billion in 2010. Recovery Audit Contractors (RACs) is one such program, implemented by Congress, as a way to manage healthcare spending by identifying improper payments to Medicare providers. Many providers are unaware of how the RAC program works, what to do if an audit letter is received, and what steps can be taken to prepare for an audit.

The History of the RAC Program

Section 306 of the *Medicare Prescription Drug Improvement and Modernization Act of 2003* contained a test program in which Recovery Audit Contractors were hired, on a contingent fee basis, to identify and correct improper payments for Medicare Parts A and B. RACs were to provide highly specialized software and skills which are not readily available to Medicare in order to identify and recover Medicare over and under payments. The program, also called demonstration project, lasted three years, beginning in 2005, and was tested in five states (California, Florida, New York, Massachusetts, and South Carolina). CMS reported $1.3 billion in improper payments identified during the three year duration of the demonstration program. The *Tax Relief and Health Care Act of 2006* included provisions for the permanent nationwide expansion of the successful RAC program effective January 1, 2010.

The *Patient Protection and Affordable Care Act of 2010* expanded the RAC program to Medicare Part C, Part D, and Medicaid Claims. The initial proposed rule required individual states to have Medicaid RAC programs implemented by April 1, 2011. However, a recent CMS bulleting published February 2011 has delayed the Medicaid RAC implementation with a new date being released in the 2011 CMS Final Rule. Funding for RAC contractors is expected to increase in the next few years Plans are to increase the budget for the RAC program from $26,000,000 in 2010 to a proposed $259,000,000 in 2011 and $500,000,000 in 2012.

Nationwide RAC Program

The nationwide RAC program will be divided into four regions, each with their own contractor (See Exhibit 1 on the last page). The regions are named by letter: Region A (Northeast), Region B (Great Lakes), Region C (South), and Region D (West). RAC contractors must include certain personnel on staff: registered nurses and therapists, certified coders, and a physician medical director. These staff members are not required to specialize in radiology. RAC contractors will review claims on a post-payment basis. Some claims will not be involved in the RAC review process, such as, claims originally denied but paid upon appeal, previously reviewed, or involved in the RAC demonstration project. There is a maximum three year look-back

period for claims review; with the earliest look back date of October 1, 2007.

Issues

Claim areas being reviewed must first be approved by a review board consisting of CMS and RAC contractor staff. These areas of review, called "issues", are approved for the RAC region contractor, not nationwide. Issues must be posted on the RAC contractor website prior to the claim audit review. Examples of approved issues pertaining to radiology are duplicate claims (Nationwide), E/M services on the same day as diagnostic mammograms (Region A: NY and CT), and technical component of radiology reductions (Region D).

The Audit Process

The RAC contractors will identify claims for audit using either specialized software or a human review. The two types of audits are *Automated Review* and *Complex Review.*

Automated Review: Review made at the system level using software without a human review of medical records. The RAC Contractor will send out a demand letter to the provider. The demand letter will include the region's RAC contractor, amount of overpayment/underpayment, a listing of claims that have been identified with the improper payment amounts, regulatory authority for improper payment, and options for repayment and appeal rights. The RAC contractors have made it clear, that in most cases, an automated review will be used. Automated claim reviews have no limitations on the amount of reviews that can be sent to a provider.

Complex Review: Defined as the application of clinical judgment by a licensed medical professional or certified coding specialist in order to evaluate medical records. Complex medical reviews will be used where there is a high probability that the service is not covered or where no Medicare policy, Medicare article, or Medicare sanctioned coding guideline exists. The RAC will first send a letter requesting medical records within 45 days. After the records have been reviewed, a review results letter is sent to the provider with the determination amount owed. If there is a determination amount, a demand letter will follow. The amount of medical records that can be requested depends on the size of the practice. In February 2011, CMS revised its limit on records (once every 45 days) for complex audits. However if locations are deemed as being sufficiently far apart (the first 3 digits of the zip code are different than the other location) that location can be considered an additional unique entity. The limit amounts per unique entity:

10 requests for less than 5 providers per campus
25 requests for 6 to 24 providers per campus
40 requests for 25 to 49 providers per campus
50 requests for 50 or more providers per campus

***Appeal and Recoupment Process*:** Since the implementation of the nationwide RAC program, providers have had success in the appeal process. In May 2011, AHA *RAC*Trac results for the nationwide RAC program, through the 1st quarter 2011, found that 25% of providers chose to appeal a RAC determination with a 72% success rate. It is essential to respond to demand letters promptly and determine if an appeal is necessary. Here are the key due dates for a demand letter:

30 Days: Appeal must be filed to suspend automatic recoupment
41 Days: Automatic recoupment begins by withholding Medicare claims
120 Days: Deadline to file an appeal

As mentioned, Medicare will begin to withhold claim payments after 41 days, using remittance advice code N432. Providers still have the option to setup payments plans or pay in full within 30 days to avoid automatic recoupment.

The first level of appeal, which must be filed within 120 days, is called a redetermination. A decision will be rendered within 60 days of the filed appeal.

Preparing for a RAC Audit

During the 3-year demonstration from 2005 to 2008, reasons for overpayment included:

40%: Medical necessity of service
35%: Incorrect Coding
8%: Lack of adequate documentation
17%: Other (duplicate denials, incorrect fee schedule, etc)

Your group should assemble a RAC team and coordinator. The coordinator, either the billing or practice manager, should be the contact person with the RAC contractor designated to receive all correspondence. Contact information can be updated with the RAC region contractor on their respective websites. In addition to a coordinator, coding staff should be assigned to determine whether an appeal should be filed and legal counsel can assist in filing an appeal.

A billing compliance audit needs to be done on a regular basis and can help identify any problem areas. Claims that pertain to approved review issues should be randomly selected and accurately verified by matching each line item with source documents. This audit can be done internally or by a third party.

A compliance program should be prepared and updated regularly by your compliance officer. The compliance program needs to include: education and training programs for your employees, regular meetings attended by a compliance committee, HIPAA risk assessments, and any modification to address specific issues.

There are also plenty of online resources and newsletters available:

The RAC contractor's websites are excellent sources for finding approved issues and contact information.
CMS has a RAC section with PowerPoint presentations on RAC topics.
LinkedIn Group- "Medicare RAC Audit Issues and Concerns" has numerous blogs and posts.
HCPro "The RAC Report" and RACmonitor: 2 free online RAC newsletters.

Exhibit 1: The Nationwide RAC Program

Region	Contractor/ Website	States in Region
A	Diversified Collection Services of Livermore, CA www.dcsrac.com	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
B	CGI Technologies and Solutions of Fairfax, VA racb.cgi.com	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
C	Connolly Consulting Associates, Inc. of Wilton, Ct www.connollyhealthcare.com/RAC	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, and the territories of Puerto Rico and U.S. Virgin Islands
D	Health Data Insights, Inc. of Las Vegas, NV www.healthdatainsights.com/RAC	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa and Northern Marianas