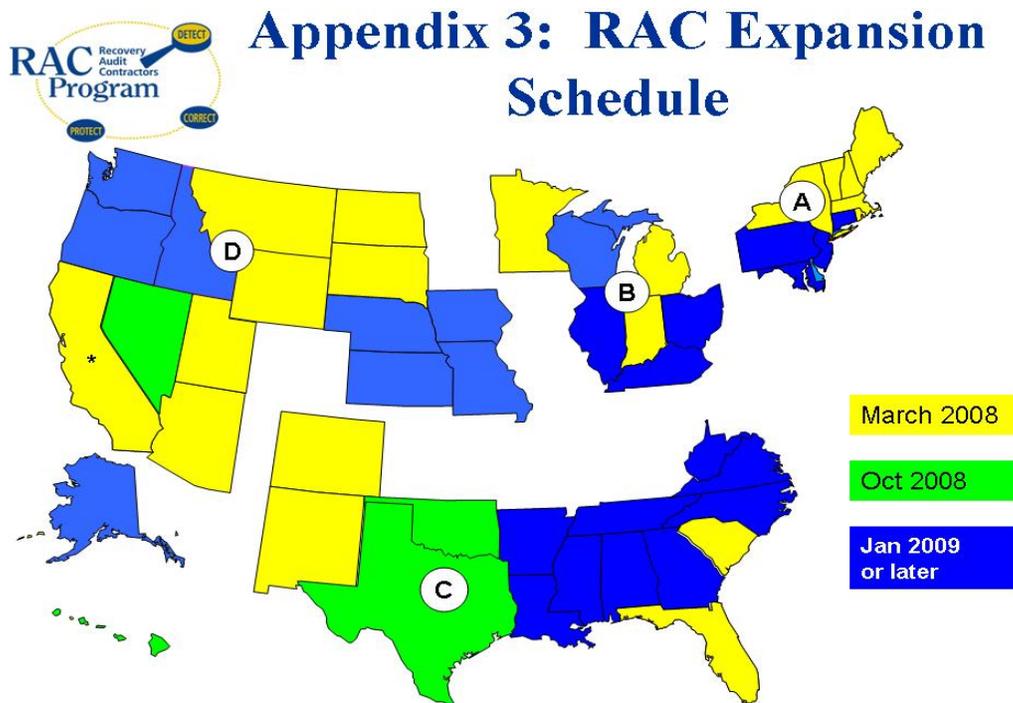


FREQUENTLY ASKED QUESTIONS

Last Updated: January 25, 2008

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

The law requires that CMS implement Medicare recovery auditing in all states by January 1, 2010. CMS will implement the program on a rolling basis, beginning in 2008. The map below shows the states that will come under review in March 2008, October 2008 and January 2009 or later.



*California claims will not be available for review from March 2008-approximately Oct. 2008 due to a MAC transition

Under this plan, CMS intends to award new contracts to four regional RACs (regions noted by A, B, C and D in the map) by April 2008. Actual claims review in the 50 states would then be phased-in over the following 18 months. Under CMS' proposed schedule, there would be a lag time before providers would begin to receive requests for medical records after the program is rolled out in each state due to the process RACs must follow to operationalize the program. It is unclear how quickly hospitals in the RAC demonstration states might begin to receive medical record requests under the expanded program, but it could start sooner than in other states as systems are already in place.

What types of claims may RACs identify and review?

RACs are required to identify Medicare claims that contain improper payments for which payment was made, or should have been made, under Medicare Part A or B. All types of Medicare providers are subject to RAC review. However, before a RAC makes a decision to reopen a claim, it must have good cause. Improper payments include:

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

A RAC may attempt to identify improper payments on claims that are paid by carriers, FIs, Medicare Administrative Contractors (MACs) and durable medical equipment (DME) MACs in their contracted regions.

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 more than three years past the date the claim was originally paid. The look-back period begins on the date the claim was originally paid and ends on the date the RAC issues the medical record request letter (for complex reviews), the date of the overpayment notification letter (for automated reviews) or three years from original payment, whichever is sooner.
- 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. 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.
- Prepayment review. A RAC may only review Medicare payments using the post payment claims review process.

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

As the program progresses over time, RACs 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, RACs will only look at federal fiscal year 2008 paid claims and forward. This policy will apply to all states, including the three states in which the RAC demonstration took place.

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

Before a RAC may begin a claim review, CMS requires that it check a master table of “excluded” claims to determine whether the claim is excluded from RAC review. Excluded claims are claims that have already been reviewed by another entity such as the Medicare contractor (FI, quality improvement organization, carrier), program safeguard contractor, MAC or law enforcement. This includes 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 Office of the Inspector General (OIG), the Department of Justice or any other law enforcement entity. These providers and/or claims are referred to as being “suppressed” and also will be included on the master table that the 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.

What process does a RAC use to identify claims overpayments and underpayments?

Claims overpayment and underpayments can only be identified when supporting evidence exists. The two primary ways through which RACs identify overpayments and underpayments are “automated review” and “complex review.”

Automated review occurs when a RAC makes a claim determination *without a human review of the medical record*. RACs use a proprietary software that is 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 incorrectly coded. 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, the RAC is required to seek approval from CMS in order to proceed with the automated review.

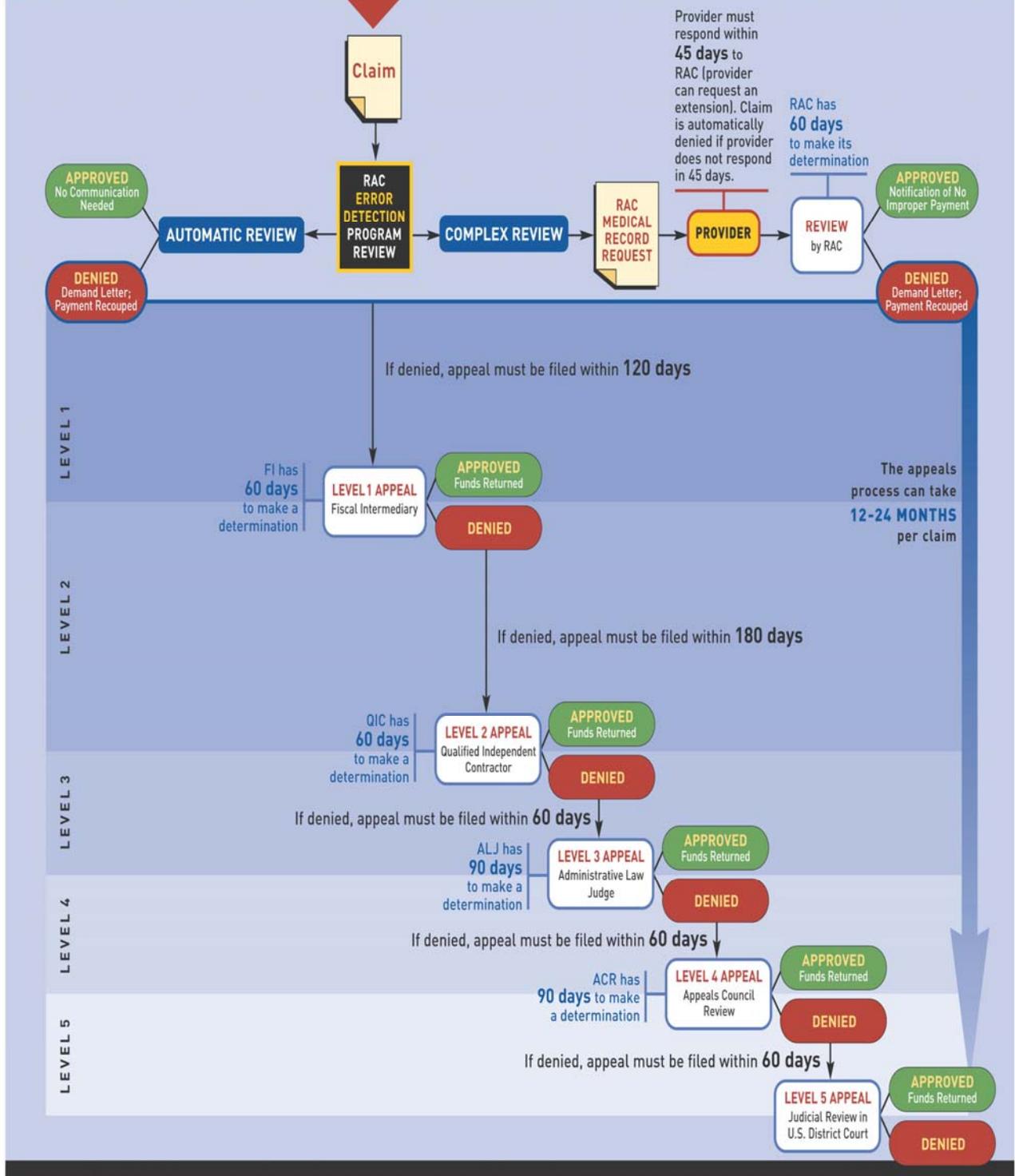
The RAC may use automated review when making other types of determinations (e.g., duplicate claims, pricing mistakes) when there is certainty that an underpayment or overpayment exists, even if written policies do not exist.

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, Medicare article or Medicare-sanctioned coding guideline exists. In complex reviews, the RAC will need copies of medical records to provide support for its decisions. Most of the focus of complex reviews has been medical necessity determinations.

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 be involved in actively examining the evidence used in making individual claims determinations.

The following chart outlines the RAC claims review and appeals process for hospitals.

RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS



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 an 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 an 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.

How will RACs 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 the good cause for reopening the claim. 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.

Are there limits to the number of records RACs may request?

CMS has stated that it will set limits on the number of medical records that a RAC may request. Different limits may apply for different provider types, and, for hospitals, the limit may be based on size of the hospital (e.g., number of beds). The limit would be per provider location and type per time period; for example, no more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45-day time period. CMS indicates that it may enact a different limit for different claim types (e.g., outpatient hospital, physicians, suppliers). The medical record request limit also may take into account a hospital's annual Medicare payments.

CMS also 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 month and the RAC does not request medical records in January and February, the RAC cannot request 150 records in March.

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

RACs are only required to pay for copies of medical records associated with acute care inpatient prospective payment system (PPS) hospital DRG claims and long-term care hospital (LTCH) 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 and \$.15 per page for non-PPS institutions and practitioner records, plus first class postage. However, hospitals and other providers, such as critical access hospitals, that are paid under a Medicare cost reimbursement system receive no photocopying reimbursement.

RACs are required to pay on at least a monthly basis for copying of inpatient PPS and LTCH medical records. CMS requires that all checks be issued within 45 days of receiving the medical record.

Also, CMS requires that RACs develop the ability to accept imaged medical records sent on compact disk or digital video device, beginning immediately, and sent via the 277 Transaction Record 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. However, providers and their clearinghouses will first need to successfully complete a connectivity and readability test with the RAC system before being able to submit imaged or electronic records to a RAC.

For claims other than acute care inpatient PPS and LTCH claims, RACs may, but are not required to, pay for medical records using any formula a RAC desires.

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 days or it may find the claim to be an overpayment. However, the RAC is required to initiate one additional contact prior to denying the claim for failure to submit documentation.

Does a provider have the right to request the status of submitted medical records?

CMS requires that RACs make information about the status of medical records (i.e., outstanding, received, review underway, review complete, case closed) available to providers upon request. CMS is requiring that all RACS, by January 1, 2010, develop a Web-based application that will be used for this purpose. Providers also would be able to use this Web-based application to customize their addresses and points of contact for RAC correspondence.

With which national and local Medicare policies and articles must RACs comply?

RACs must comply with all NCDs, coverage provisions in interpretive manuals, national coverage and coding articles, local coverage determinations (LCDs), local coverage/coding articles in their 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 RAC 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 level of RAC staff is involved in performing complex coverage/coding reviews?

CMS requires that, when a RAC conducts a complex review, coverage and medical necessity determinations be made by registered nurses or therapists and coding determinations be made by certified coders. If requested by the provider, a RAC must supply information about the credentials of the individuals making the medical review determinations. A RAC also must make its CMD available to discuss a claim denial if the provider requests it.

Are RACs required to employ physician medical directors?

CMS requires that each RAC employ a minimum of one full-time equivalent (FTE) 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.

Within what time frame must a RAC complete complex coverage and/or coding reviews?

A RAC must complete a complex review within 60 days from receipt of the medical record documentation. RACs may request a waiver from CMS if an extended time frame is needed due to extenuating circumstances. If an extended time frame for review is granted, RACs are required to notify the provider in writing or via a Web-based application of the situation that has resulted in the delay, and must indicate that the Notification of Findings will be sent once CMS approves the RAC to move forward with the review.

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 carrier or FI failed to apply a payment rule, thus causing an improper payment. An example would be the 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 Medicare carrier, FI or other 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 Medicare overpayments.

How will RACs identify and process underpayments?

RACs will review claims using automated or complex reviews to identify potential Medicare underpayments. Upon identification, a RAC will communicate the underpayment finding to the appropriate Medicare FI, carrier or other contractor. The 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.

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 would create 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.

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.

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

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

The RAC may send a provider only one review results per claim that contains the results of each type of review to which the claim was subjected. The RAC also may send a provider one notification (or demand) letter that contains a list of all the claims denied for the same reason.

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

These letters must include:

- identification of the provider;
- the reason for conducting the review;
- a narrative description of the overpayment situation stating the specific issues involved that created the improper payment and any pertinent issues, as well as any recommended corrective actions the provider should consider taking;
- the findings for each claim in the sample, including a specific explanation of why any services were determined to be non-covered or incorrectly coded;
- a list of all individual claims including the actual amounts determined to be non-covered, the specific reason for non-coverage and the amounts denied;
- instructions to debtors to forward refund checks, payable to the Medicare program, to the appropriate address at the applicable Medicare contractor (FI, carrier, durable medical equipment MAC or MAC);

- for statistical sampling for overpayment estimation reviews, any information required by Medicare regulation;
- an explanation of the provider's or supplier's right to submit a rebuttal statement prior to recoupment of any overpayment;
- an explanation of the procedures for recovery of overpayments, including Medicare's right to recover overpayments and charge interest on debts not repaid within 30 days, and the provider's right to request an extended repayment schedule;
- the provider appeal rights information; and
- other demand letter requirements for written notifications.

If a letter is being sent regarding a Medicare Part A overpayment, it is referred to as "written notification of overpayment." If it references a Part B overpayment, the letter is referred to as a "demand letter." CMS is moving toward the use of standardized base letters.

How are overpayments recouped?

RACs are required to pursue the recoupment of Medicare overpayments they identify. The recovery techniques used by a RAC must be legally supportable and follow CMS regulations, manuals and federal debt collection standards.

A RAC may not attempt to recoup or forward claims to the Medicare contractor for adjustment if the overpayment is less than \$10. Similarly, underpayments that are less than \$1 cannot be forwarded for adjustment.

Recoupment is defined as the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare provider payments and applying the amount withheld to reduce the debt. The entire overpayment is recouped, but the overpayment should be net of the correct payment amount identified by the RAC. Overpayments identified and demanded by a RAC will be subject to the existing Medicare withholding procedures. The appropriate Medicare FI, carrier, MAC or other contractor will handle the withholding of present and future payments. These withhold procedures will be used for all provider overpayments.

Once payments are denied, the withhold remains in place until the debt is satisfied in full or alternative payment arrangements, such as a payment plan, are made. As payments are withheld, they are applied against the oldest outstanding overpayment. All payments are first applied to interest and then to principal. Interest accrues from the date of the demand letter and in accordance with regulation.

Outside of the process described above, the RAC can determine the recovery methods it chooses to utilize.

The demand letters issued by the RAC will instruct debtors to forward their refund checks to the appropriate address at the applicable Medicare contractor (FI, carrier, DME MAC or MAC). All refund checks shall be payable to the Medicare program.

Can a provider choose repayment through an installment agreement?

RACs are required to offer providers the ability to repay the overpayment through an installment plan and can approve plans of up to 12 months in length. If a provider requests an installment plan over 12 months in length, the RAC must seek approval from CMS. While the RAC cannot deny an installment plan request, it can recommend denial to CMS.

When is a provider's debt considered delinquent, and what happens then?

CMS is required to refer all eligible debt over 180 days delinquent to the Department of Treasury for cross-servicing and further collection activities. Debt is considered to be "delinquent" if: (1) the debt has not been paid in full or otherwise resolved by the date specified in the agency's initial written notification, unless other payment arrangements have been made; or (2) at any time thereafter, the debtor defaults on a repayment agreement. Debt not eligible for referral includes debt: (1) that is in appeal status (pending at any level); (2) where the debtor is in bankruptcy; (3) that is in litigation (in which the federal government is involved as a party); and (4) where there is a pending request for a waiver or compromise. The RAC Statement of Work describes other situations in which debt is ineligible for referral.

A RAC is required to issue a written notification to the debtor stating that it intends to refer the debt to the Department of Treasury within a certain defined time frame. Once the FI, carrier or other Medicare contractor refers the debt to the Department of Treasury, the RAC must cease all recovery efforts.

Can RACs negotiate a compromise or settlement agreement with a provider?

A RAC does not have authority to compromise or settle an overpayment. If the provider presents the RAC with a compromise or settlement offer (or a consent settlement request), the RAC must forward the overpayment case and all supporting documentation to CMS for direction. The RAC also is required to send its recommendation regarding the compromise request to CMS.

What occurs if a provider voluntarily self-reports an overpayment?

A RAC is required to cease all recovery efforts for the claims involved in the self-report immediately upon becoming aware of the self-reporting through notification from the provider or another Medicare contractor. However, if the self-report from the provider

does not involve the same types of services for which the RAC had issued a demand letter or a request for medical records, then the RAC may continue recovery efforts.

What happens to RAC recoupment efforts when a provider appeals?

Every written notification of overpayment and demand letter will contain provider appeal rights. If a provider files an appeal with the appropriate entity within the appropriate time frame, the RAC is required to follow all CMS guidance regarding the limitation on recoupment. Once the RAC is notified of the appeal request, it must cease all recovery efforts. After the reconsideration level of the appeal process by the Qualified Independent Contractor (QIC) is completed (or the first level of appeal if the QIC reconsideration process has not been implemented yet), the RAC must resume recovery efforts if the decision was not favorable to the provider.

The clock counting days of debt delinquent for Department of Treasury debt referral purposes will cease while recovery efforts are stopped during the appeal process. However, interest will continue to accrue from the date of the demand letter throughout the appeals process.

How does interest accrue for overpayments and underpayments?

Interest will accrue from the date of the final RAC determination and will be charged on either the overpayment balance or paid on the underpayment balance for each full 30-day period that payment is delayed. The interest rate in effect on the date of final determination is the rate that will apply for the entire life of the overpayment. When payments are received, they will be first applied to any accrued interest and then to the remaining principal balance.

What type of customer service must RACs provide?

RACs must provide the following services:

- Toll-Free Number. RACs 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.
- Knowledgeable Customer Service Staff. CMS requires that the staff answering the customer service lines be knowledgeable of the RAC program. The staff must have access to all identified improper payments and must be knowledgeable of all possible recovery methods and the appeal rights of the provider. The 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. RACs must use a quality assurance program to ensure that all customer service representatives are knowledgeable, being

respectful to providers and providing timely follow-up calls when necessary. CMS staff may monitor these calls.

- Timeliness in Response to Written Correspondence. RACs are 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 is 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 was satisfied with all improvements made in the customer service area.
- Provider Education. A RAC is only permitted to educate providers on the RAC's business, its purpose and process. RACs are *not* permitted to educate providers on Medicare policy.
- RAC Web Page. RACs are required by January 1, 2010 to develop and maintain a Medicare RAC Web page to communicate helpful information to the provider community.

How may an overpayment determination be appealed?

Providers have appeal rights for the majority of Medicare overpayments determined during the post payment review process. If a provider chooses to appeal an overpayment determined by a RAC, the RAC must assist CMS throughout all levels of the appeal.

Providers must request an appeal through the appropriate Medicare appeals process. A third party will adjudicate all appeal requests related to provider overpayments identified by the RAC. This third party may be the current Medicare contractor, a third-party contractor identified by CMS, a QIC, an Administrative Law Judge, or the Department of Health and Human Service's Departmental Appeals Board's Medicare Appeals Council. Some recovery claims may eventually be appealed to the appropriate federal court.

If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's favor at any level, the RAC is required to repay Medicare the contingency payment for that recovery.