American Hospital Association

Member Advisory

AHA Audit Education Series

June 14, 2012

MEDICARE RECOVERY AUDIT CONTRACTORS (RACs): PERMANENT PROGRAM BASICS

AT A GLANCE

The Issue:

Section 302 of the 2006 *Tax Relief and Health Care Act* required the Centers for Medicare & Medicaid Services (CMS) to implement a nationwide Recovery Audit Contractor (RAC) program by 2010. Medicare RACs are charged with correcting improper payments made to Medicare providers. RACs began reviewing Medicare provider payments in October 2010. According to CMS, RACs "corrected" $1.45 billion in improper payments by December 2011.

This advisory provides an overview of the permanent Medicare RAC program and the changes CMS has made to program policies and procedures over the last few years. It describes guidelines RACs must follow, program requirements for hospitals and new developments in the program including its expansion to Medicaid and the rebilling and prepayment review demonstration projects.

If your RAC is not adhering to program policies and requirements prescribed by CMS and outlined in this advisory, it is important to raise the issue directly with your RAC representative. If you do not receive a satisfactory response, report the issue to your CMS RAC project officer, whose contact information is on pages 5 and 6 of this advisory. If the issue still is not resolved, contact the AHA using the contact information listed below.

Our Take:

While the AHA has been successful in improving the RAC program, several concerns remain. The AHA continues to urge CMS and Congress to make changes; however, hospitals should take steps now to improve payment accuracy and avoid RAC denials. See the AHA Advisory on Reducing Vulnerabilities to Payment Denials for strategies and resources to reduce your vulnerabilities to program integrity auditors. Hospitals should appeal inappropriate denials and may consult the AHA Advisory on the Medicare Appeals Process for more information. Also participate in the AHA Audit Education Series, which includes a series of webinars and new resources designed to help you reduce your vulnerability to payment denials. Finally, provide your RAC experience data to AHA's *RAC*Trac initiative, which assesses the program's impact on hospitals. Data from *RAC*Trac is used to support AHA's RAC advocacy efforts and also to assist hospitals in taking proactive steps to prevent improper payments. Visit www.aha.org/rac for additional AHA member resources and learn more about *RAC*Trac and how to participate in our Quarterly Nationwide *RAC*Trac webinars.

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.
- Participate in AHA's Audit Education Series

Further Questions:

Please contact Don May, AHA vice president of policy, at (202) 638-1100 or e-mail RACinfo@aha.org.

A 29-page, in-depth examination of this issue follows.

American Hospital Association Member Advisory AHA Audit Education Series

June 14, 2012

MEDICARE RECOVERY AUDIT CONTRACTORS (RACS): PERMANENT PROGRAM BASICS

BACKGROUND

Congress established the Medicare Recovery Audit Contractor (RAC) program as a three-year demonstration in the *Medicare Modernization Act of 2003*. The demonstration began in California, Florida and New York and expanded to Massachusetts and South Carolina in 2007 before ending on March 27, 2008. The Centers for Medicare & Medicaid Services (CMS) reported collecting $980 million in overpayments from Medicare providers during the demonstration. The 2006 *Tax Relief and Health Care Act* made the RAC program permanent and required its expansion to all 50 states by no later than January 1, 2010.

RACs seek 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 mistakes and coding errors. In addition, RACs can request medical records to review coverage, medical necessity 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.

CMS divided the country into four geographic RAC regions and awarded contracts to four separate companies. The RACs began auditing providers in October 2010 and, as of December 2011, CMS reported that the program had corrected $1.45 billion in improper payments, including $1.27 billion in overpayments and $183.7 million in underpayments.

This advisory provides an overview of the permanent RAC program and includes all the changes CMS has made to program policies and procedures over the years. The advisory also describes recent developments in the program, including the expansion of the program to Medicaid and the new rebilling and prepayment review demonstration projects.

If your RAC is not adhering to program policies and requirements prescribed by CMS and outlined in this advisory, it is important to raise the issue directly with your RAC representative. If you do not receive a satisfactory response, report the issue to your CMS RAC project officer. Contact information for the project officers can be found on

pages 5 and 6 of this advisory. If the issue is still not resolved, contact the AHA at (202) 638-1100 or e-mail RACinfo@aha.org.

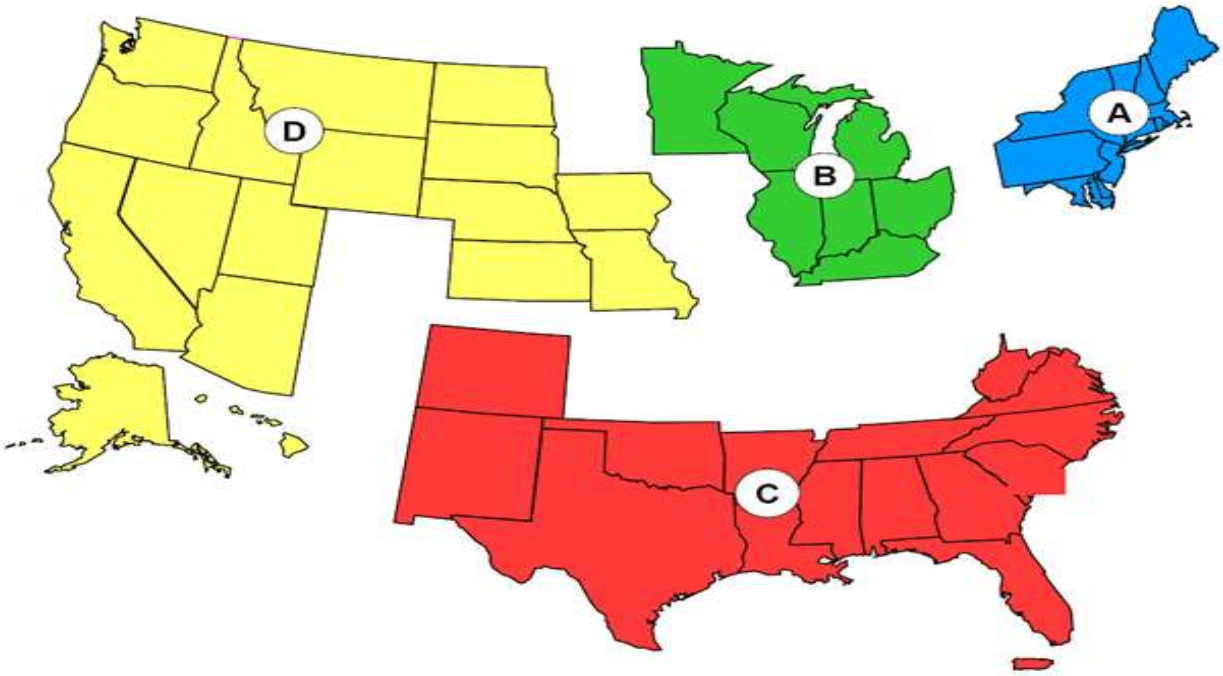
While the AHA has worked successfully to improve the RAC program, concerns remain. We will continue to urge CMS and Congress to make changes; however, hospitals should take steps to improve payment accuracy and avoid RAC denials. See the AHA Advisory on Reducing Vulnerabilities to Payment Denials for strategies and resources to reduce your vulnerabilities to program integrity auditors. Also participate in the AHA Audit Education Series and visit www.aha.org/rac for additional AHA member resources. Hospitals should appeal inappropriate denials; consult the AHA Regulatory Advisory on the Medicare Appeals Process for more information.

It also is important to provide your RAC experience data to AHA's *RAC*Trac initiative, which assesses the program's impact on hospitals. Data from *RAC*Trac is used to support AHA's RAC advocacy efforts and also to assist hospitals in taking proactive steps to prevent improper payments. Visit www.aha.org/rac for additional AHA member resources and learn more about *RAC*Trac and how to participate in our Quarterly Nationwide *RAC*Trac webinars.

SUMMARY

RAC Regions and Assignments

CMS solicited bids and awarded contracts to four Medicare RACS, each covering a geographic region. (Region A, B,C, and D below). According to CMS, 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." CMS 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. Since 2008, CMS has elected to renew the option for all four RACs.

CMS requires each RAC to agree to a Statement of Work (SOW), which contains many of the policies and requirements described in this advisory. CMS revised the SOW in September 2011. RACs often also contract with subcontractors to assist with payment reviews. CMS does not directly contract with these subcontractors. The table below shows the RAC contactors by geographic region.

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

RAC Contingency Fees

RACs are paid a percentage of each improper payment they identify. The contingency fee is the same regardless of whether the RAC identifies an overpayment or an underpayment. CMS sets the RAC contingency fee at the beginning of each RAC contract. Current RAC contingency fees are included in the table below and are posted on CMS's website at https://www.fbo.gov/index?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&_cview=1&cck=1&au=&ck. 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 the entire 60 months of the contract.

RAC Region	Medicare Recovery Audit Contractor	Contingency Fee Percentage
A	DCS	12.45%
B	CGI	12.50%
C	CONNOLLY healthcare	9.00%
D	HealthDataInsights™	9.49%

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

RAC Staffing Requirements

CMS requires that, for a complex review of a medical record, 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.

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

RAC and CMS Contact and Customer Service Information

All management of the RAC program is handled by the CMS central office in Baltimore. In addition to a RAC director and deputy director, CMS assigns project officers to oversee operations in each of the four RAC regions. Contact information for CMS RAC staff and each RAC's customer service is listed below.

Connie Leonard
Director, Division of Recovery Audit Operations
Provider Compliance Group

Office of Financial Management, CMS
Phone: (410) 786-0627
E-mail: connie.leonard@cms.hhs.gov

Marie Casey
Deputy Director, Division of Recovery Audit Operations
Provider Compliance Group
Office of Financial Management, CMS
Phone: (410) 786-7861
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Scott Wakefield
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Provider Compliance Group
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Amy Cinquegrani
Health Insurance Specialist
Provider Compliance Group
Office of Financial Management, CMS
Phone: (410) 786-8627
Email: amy.cinquegrani@cms.hhs.gov

RAC Region	Medicare Recovery Audit Contractor	RAC Contact Information	CMS RAC Project Officers
A	DCS	**1-866-201-0580** **info@dcsrac.com** **www.dcsrac.com**	**Ilene Jacob** **Ilene.Jacob@cms.hhs.gov** **410-786-7444**
B	CGI	**1-877-316-7222** **racb@cgi.com** **www.racb.cgi.com**	**Tamara Tate** **Tamara.tate@cms.hhs.gov** **(410) 786-1128**
C	CONNOLLY healthcare	**1-866-360-2507** **RACinfo@connollyhealthcare.com** **www.connollyhealthcare.com**	**Olive Taylor** **Olive.Taylor@cms.hhs.gov** **(410) 786-1207**
D	HealthDataInsights™	**Part A: 1-866-590-5598** **Part B: 1-866-376-2319** **racinfo@emailhdi.com** **www.healthdatainsights.com**	**Narcessa Davis** **Narcessa.Davis@cms.hhs.gov** **(410) 786-2915**

*Please note that CMS RAC project officers change on a regular basis. Check directly with CMS for the most current project officer in your region. All general questions related to the RAC program can be sent to RAC@cms.hhs.gov. You also can visit the frequently asked questions (FAQ) section (http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_pv=4.497) of the CMS website, or the RAC section (www.cms.hhs.gov/rac) for program updates.

Each RAC is required to provide the following customer services, and providers should alert CMS if a RAC is not meeting these requirements:

- 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 and Education. Prior to the implementation of the permanent program, RACs were required to conduct provider outreach and provide education on the RAC process. The AHA and state hospital associations partnered with CMS and RACs to facilitate the outreach.

- RAC Website. Each RAC is required to maintain a Medicare RAC website to communicate helpful information to the provider community. The website must include:

    - **New Issue Review Page**. Upon CMS approval to review a payment issue, RACs must post the issue name, description, and posting date, and state the applicable provider type and any relevant Healthcare Common

Procedure Coding System code or Diagnosis Related Group (DRG) code. The new issue listing shall be sortable by provider type, and CMS encourages RACs to sort the listings by postdate, state and claim type.

- **Provider Contact Portal.** The website must contain a mechanism to allow providers to customize their address and point of contact.

- **Medical Record Tracking.** The website must maintain a log of all requests for medical records indicating at least the requester, a description of the medical record being requested, the date the request was received and the date the request was fulfilled. The website also must provide the status of a medical record (outstanding, received, review under way, review complete, case closed).

Payments and Providers Subject to RAC Review

Types of Providers. Medicare RACs conduct reviews of Medicare Parts A and B claims paid by carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (MACs) or other primary claims processing contractors within the RAC's jurisdiction. 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 (DME) suppliers, are subject to RAC review. Critical access hospitals and periodic interim payment (PIP) hospitals also are subject to RAC review. Because PIP hospitals are paid differently than prospective payment system (PPS) hospitals, CMS issued a FAQ to address how RACs will audit PIP hospitals. The document can be accessed at http://www.cms.gov/Recovery-Audit-Program/Downloads/RACfaq.pdf.

Types of Improper Payments. When reviewing a claim, RACs look for improper payments, including:

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

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 or review cost report settlement issues, such as indirect medical education or direct graduate medical education payments.

- 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 Payment Reform Demonstration 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.

- 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 Department of Health and Human Services' Office of Inspector General (OIG).

Three-year Look-Back Period. RACs may review all claims paid within the past 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. RACs may seek an exception from CMS to the three-year, look-back period.

RACs that violate the three-year look-back period without an exception from CMS may not receive their contingency fee for any improper payments identified. Providers should report all such instances to CMS to ensure the RAC does not receive its contingency fee.

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.

Before a RAC reviews a claim that is more than one year past the date of initial payment determination, it must have "good cause." To demonstrate "good cause," the RAC must present new evidence that was not available or known at the time a payment or appeals decision was made or the RAC must provide evidence that clearly shows the payment or appeal decision contains an obvious error or fraud. See AHA's Medicare Appeals Member Advisory, available at **http://www.aha.org/advocacy-issues/tools-**

resources/advisory/2012/120614-member-adv.pdf, for more information on this topic.

RAC Review Process

Selecting Issues to Review. CMS requires a RAC to present data analysis or other evidence of improper payments before it proceeds in wide-scale review of claims. CMS established the New Issue Review Board to review and approve every issue – whether it results in an overpayment or underpayment – that will be subject to RAC review. The board is comprised of several CMS staff members and the agency's contractors, including CMS RAC project officers, the RAC validation contractor, the appropriate MAC/FI/carrier, the Center for Medicare Management within CMS and others. RACs must present evidence of an improper payment to the board. 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, RACs must cite Medicare policy and/or findings from the OIG, Quality Improvement Organization (QIO) reports, the national Medicare program manual and national or local coverage determination documentation.

Total Number of CMS-Approved RAC Issue Review Requests
As of March 2012

Type of Review	Total Number of CMS-Approved Issue Review Requests
Automated	300
Complex—Medical Necessity	802
Complex—Coding	545
Semi-Automated	24
TOTAL	**1,671**

Moreover, RACs must describe to the board 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, must be posted to the RAC's website 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 websites for information about the areas that may be targeted for audit. Providers should alert CMS if a RAC attempts to review an issue that has not been approved by CMS and/or has not been posted on the RAC's website.

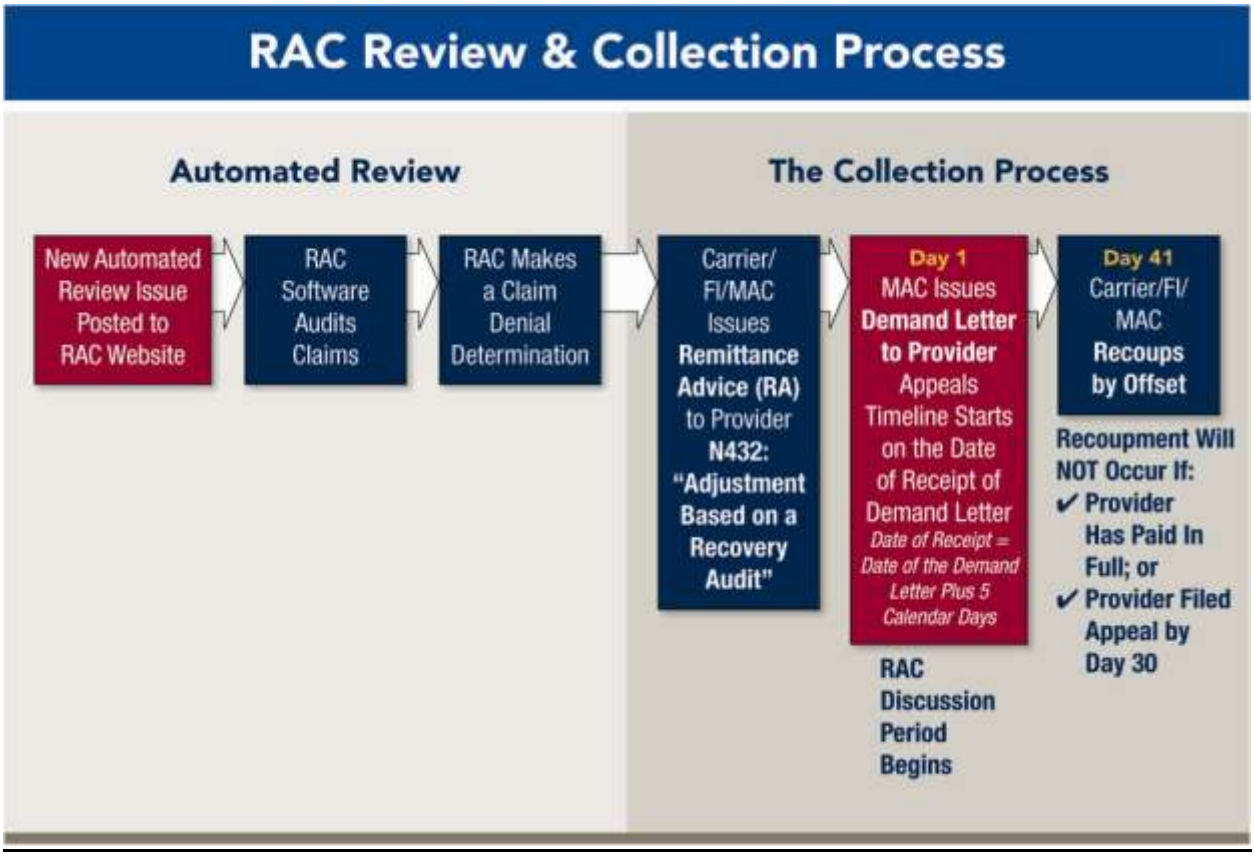
Types of RAC Reviews. RACs identify overpayments and underpayments in three ways: automated review, semi-automated review and complex review.

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.

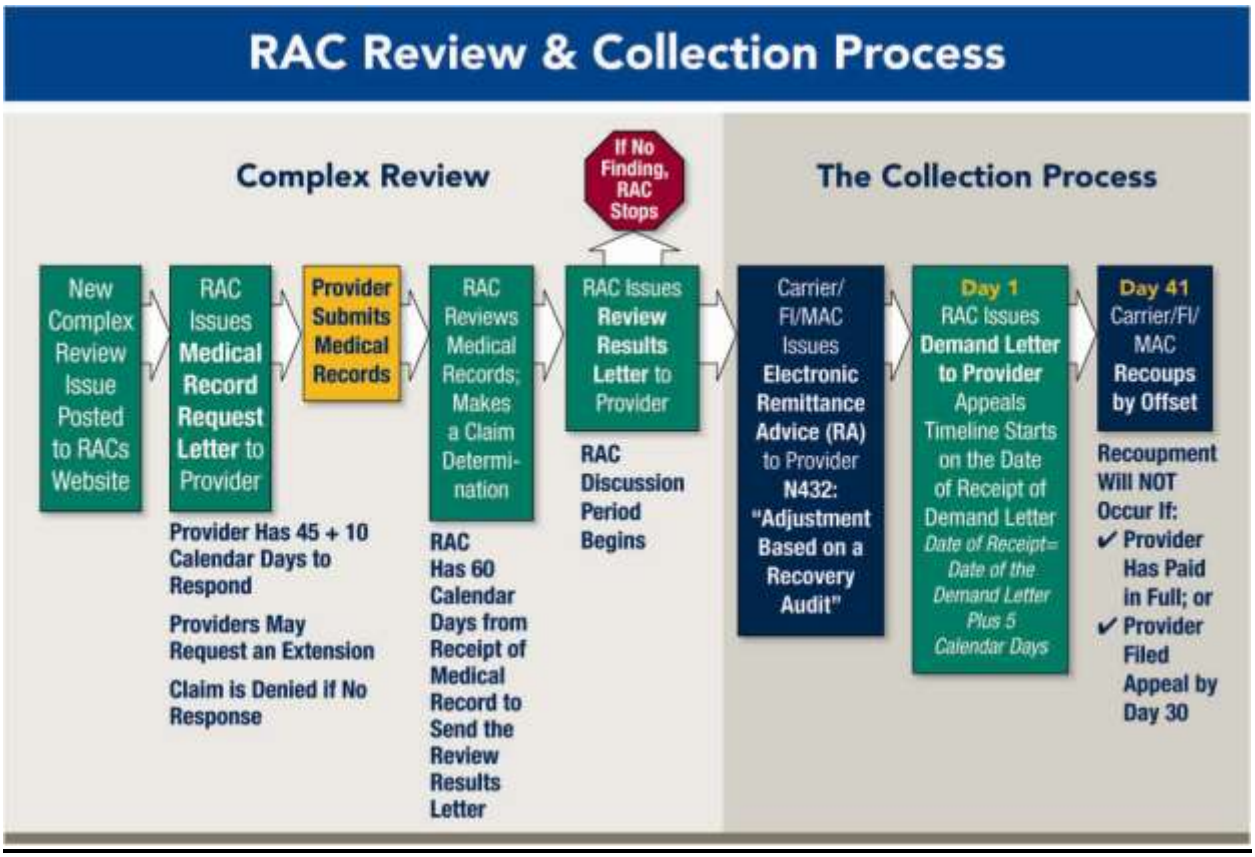


Semi-automated review is a new, two-part review CMS introduced to the RAC program in 2010. The first part of the review is the identification of a billing aberrancy through an automated review using claims data. The second part includes a notification letter that is sent to the provider explaining the potential billing error that is identified. The letter also indicates that the provider has 45 days to submit documentation to support the original billing. If the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued. However, if the RAC determines the submitted documentation does support the billing of the claim, the claim will not be sent for adjustment and the provider will be notified that the review has been closed. This type of review is used in instances where the items and services as billed are considered "clinically unlikely or not consistent with evidence-based medical literature," and a clear CMS policy does 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, 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 the 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 claim determinations." In these reviews, the RAC must use appropriate medical literature and apply appropriate clinical judgment. The RAC contractor's medical director (CMD) must actively examine the evidence used in making individual claims determinations where the Medicare guidelines or literature are unclear.

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



Medical Record Review

CMS grants RACs authority to request medical records from providers when conducting complex reviews and limits RACs to a certain number of medical record requests, commonly referred to as additional documentation requests (ADRs).

ADR Limits. CMS's ADR policy (http://www.cms.gov/Recovery-Audit-Program/Downloads/Providers_ADRLimit_Update-03-12.pdf) establishes an individual ADR limit per 45 day period for each hospital campus. A hospital campus is defined as one or more facilities under the same tax identification number located in the same area (determined by the first three digits in the ZIP code).

Each ADR limit is based on all of the provider's prior calendar year Medicare claims volume only and is equal to 2 percent of all claims submitted for the previous calendar year divided by 8. A provider's ADR limit is applied across all claim types, including professional services.

RACs calculate a provider's ADR limit and include it on the ADR letter sent to providers. Hospitals should verify that the RAC has calculated the appropriate limit. If a provider believes that there has been an error in the calculation, it should first contact its RAC's customer service line, and if it is not resolved, the provider should contact its CMS RAC project officer.

RACs may issue an ADR to the hospital only once every 45 days, although they may go more than 45 days between record requests. RACs that issue ADRs more than once in a single 45-day period should be reported to CMS.

While CMS's policy states the maximum number of ADRs per 45-day period is 400, the policy allows the agency to grant RACs permission to exceed this limit. In 2012, CMS allowed several RACs to begin requesting up to 600 medical records from larger hospitals per 45-day period. CMS's policy also allows RACs to request up to 35 records per 45 days for providers whose calculated limit is 34 ADRs or less.

CMS issued separate ADR limit policies for physicians and non-physician practitioners (http://www.cms.gov/Recovery-Audit-Program/Downloads/PhyADR.pdf) and for DME suppliers (http://www.cms.gov/Recovery-Audit-Program/Downloads/FY2011Limits.pdf).

ADR Letters. All ADR 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.

Each RAC uses a standard ADR letter and is required to post that letter on its website. The ADR letter must include the hospital-specific ADR limit calculated by the RAC using the formula described above. Hospitals should verify that the ADR limit the RAC has calculated is correct.

ADR Submission and Timeframe. Currently, providers may submit medical records on paper through the mail, via fax or by scanning images of the medical records to a CD or DVD. In September 2011, CMS introduced a new mechanism to allow hospitals to submit medical records electronically, the Electronic Submission of Medical Documentation (esMD), which is discussed in the next section of this advisory.

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 allows 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.

Electronic Submission of Medical Records. On September 15, 2011, CMS began phase one of its new esMD program, which allows providers to electronically submit medical documentation to the RAC. CMS indicates that in order to participate in the esMD program, providers must obtain access to a "CONNECT-compatible gateway." Although some hospitals may choose to build their own gateway, CMS anticipates that many providers will choose to obtain gateway services by entering into a contract or

other arrangement with a Health Information Handler (HIH) that offers esMD gateway services. For more information on the esMD program, including a list of which HIHs offer esMD gateway services, visit the CMS esMD website: http://www.cms.gov/ESMD/01_Overview.asp#TopOfPage

The esMD program is voluntary. Providers who are content with faxing or mailing documentation to their RAC may continue to do so. However, providers who believe it would be more efficient to respond to documentation requests electronically may contact one or more of the HIHs to determine if esMD services are available to the provider for a reasonable price. During phase 2 of esMD, RAC ADR requests will be electronic. CMS has not provided an implementation date for phase 2 of the esMD program. The AHA is urging CMS to expand phase 2 of the program to make *all* RAC/MAC correspondence (demand letters, review results letters, etc) electronic.

Reimbursement for Medical Records. A RAC is required to pay only for copies of medical records associated with acute-care inpatient PPS hospital 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, but is not required to reimburse more than $25 per medical record for any medical record received after April 1, 2012 according to a policy CMS adopted in March 2012. This includes the current rate for medical records photocopying of 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 copying 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.

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 apply this policy, please contact your RAC directly.

CMS requires RACs to accept imaged medical records sent on CD or DVD. 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.

Tracking ADRs. CMS requires a RAC to make information about the status of medical records (i.e., outstanding, received, review under way, review complete, case closed) available to providers upon request. RACs must make this information available on their website under the provider portal. If providers have any issues tracking the status of the ADRs, hospitals should contact CMS.

On-Site Record 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.

RAC Determinations

Types of RAC Determinations. 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). This includes denials commonly referred to as "medical necessity denials" and includes denials for medically necessary care that the RAC has determined was provided in the wrong setting, i.e. inpatient vs. outpatient.

- 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.

Applicable Medicare Policies and Local Coverage Decisions. 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.

RAC Screening Tools (i.e. InterQual, Milliman). A RAC cannot deny a claim just because it fails to meet InterQual, Milliman or any other screening tool criteria. Nor should a provider assume that just because a claim passes InterQual, Milliman or any other kind of screening tool that the service is covered by Medicare. If the RAC chooses to utilize one of these publicly available products, CMS indicates that the information should be shared with providers. For more information, contact your RAC directly.

RAC Determination Timeframe. 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 in writing or via a web-based application of the situation that has resulted in the delay. RACs that fail to comply with the 60-day requirement may not receive their contingency fee. Hospitals should inform CMS when RACs fail to meet the 60-day determination deadline.

RAC Denials. 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, up-coded 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 "reasonable and necessary" level of service that represents the correct code for the service described in the medical record. The actual overpayment amount is determined when the claims processing contractor completes a claim adjustment and notifies the RAC of the amount to be recovered. A RAC can collect only 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. 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.

Notification of RAC Determinations. 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 website.

The demand letter will come from the provider's MAC or FI 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 provider's option to submit a rebuttal statement (described in the AHA Medicare Appeals advisory available at http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120614-member-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.

See a sample demand letter on AHA's website at http://www.aha.org/content/11/samplemacdemandltr.pdf

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 for which no improper payment has been 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.

For complex reviews **where an overpayment has been identified**, there will be TWO communications sent to the provider. 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 within 60 days of the exit conference, required to be conducted at the end of provider on-site reviews) unless CMS grants an extension. RACs that fail to meet the 60-day requirement forfeit their contingency fee; providers should notify CMS when the RAC has missed the 60 day deadline.

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.

Subsequent to the review results letter that notifies the provider that an overpayment has been identified as part of the complex review, the provider's MAC or FI will send a follow-up **demand letter** to the provider. The time between the review results letter and the demand letter may be a matter of days. The demand letter 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/advocacy-issues/tools-resources/advisory/2012/120614-member-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.

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."

The Remark Code often gives the impression that the denial amount has already been recouped from the provider. Confirm with your financial staff as this is often not the case. This code on the remittance advice is notice that a recoupment will occur unless the provider takes action within the appropriate timeframe, by either appealing the denial or processing a repayment to the contractor.

Providers may file their appeal with the MAC as soon as the remittance advice signals that a denial has been issued. If your MAC refuses to accept the appeal without a copy of the demand letter, contact CMS to correct the problem.

RAC Recoupments

RACs are required to pursue the recoupment of Medicare overpayments they identify. The recovery techniques used by a RAC must be legally supported 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 are issued by the MAC and instruct providers 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 made payable to the Medicare program.

Repayment Installment Plans. 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.

Provider Debt. 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 timeframe. Once the FI, carrier or other Medicare contractor refers the debt to the Department of Treasury, the RAC must cease all recovery efforts.

Compromise or settlement agreement. 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. The RAC also is required to send its recommendation regarding the compromise request to CMS.

Appeal Impact on Recoupment. Every written notification of overpayment and demand letter will contain a description of provider appeal rights (see more on appeals later in this advisory). 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 appeals process. However, interest will continue to accrue from the date of the demand letter throughout the appeals process.

Interest. 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 applied first to any accrued interest and then to the remaining principal balance. If the provider appeals a denial, interest will continue to accrue from the date of the demand letter throughout the appeals process.

Self-Reporting Improper Payments

When a provider self-reports an improper payment, 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.

The *Patient Protection and Affordable Care Act of 2010* (ACA) requires a health care provider or supplier that received an overpayment from the Medicare program to report and return the overpayment by the later of 60 days after the date the overpayment was identified, or the date any corresponding cost report is due, if applicable. Failure to meet the deadline can result in liability under the *False Claims Act* (FCA) resulting in significant financial penalties and provider expulsion from the Medicare program.

CMS issued a proposed rule on February 14, 2012 to implement the new ACA provision. The proposed rule presents many concerns for hospitals, imposing a broad

and ill-defined new duty to investigate potential overpayments that is beyond what Congress intended and at odds with existing processes for addressing billing mistakes. The consequences of a hospital's failure to satisfy this new duty could be severe: The proposed rule effectively converts a neutral process for returning overpayments into a new kind of fraud, where a provider's failure to investigate potential overpayments adequately in the eye of a regulator becomes the basis for liability under the FCA. These new and unjustified burdens and legal risks are made worse by the creation of a 10-year "look-back" period for identifying an overpayment.

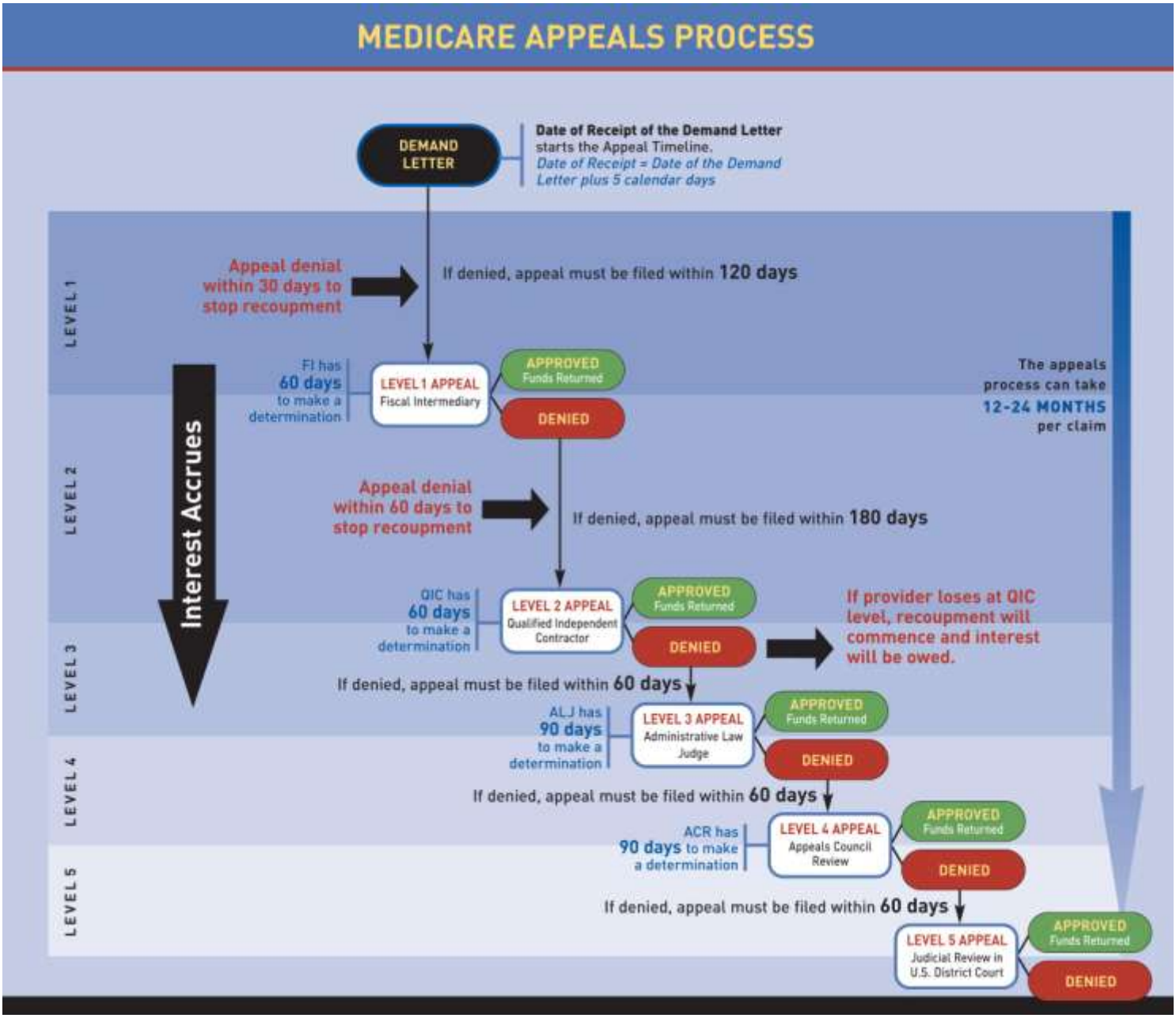
The AHA has urged CMS to act promptly to remedy the confusion the rule has created regarding the intersection of the proposed rule and existing processes related to the various types of government audits and reviews of providers (e.g., RACs and MACs). The AHA also is urging CMS to confirm that the rule does not apply to any claims or issues that are the subject of any government review.

For more information see the AHA's Legal Advisory on the proposed rule (http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2012/120314-legal-adv.pdf).

Appeals

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 is on the next page**.** For more information on the Medicare Appeals process, please review AHA's Medicare Appeals advisory at http://www.aha.org/advocacy-issues/tools-resources/advisory/2012/120614-member-adv.pdf.



Discussion Period. CMS requires each RAC to 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.

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.

The revised RAC Statement of Work requires providers to submit a discussion request to the RAC in writing and requires the RAC to respond to the request within 30 days of receipt. If a provider files an appeal during the discussion period, the RAC is required to immediately discontinue the discussion period and send a letter to the provider informing it that the RAC cannot continue the discussion period once the appeal has been filed.

If the RAC reverses or modifies its denial during the discussion period, written notification must be sent to the provider so that the provider can share this information with the appeal entity. If the claim has already been forwarded to the MAC for adjustment, the RAC shall immediately notify the MAC that the claim no longer requires adjustment.

The RAC must grant all requests by a physician (or a physician employed by a hospital) to speak with a RAC about a denial.

Rebilling

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 be allowed *only* 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 12 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.

Part A to Part B Rebilling Demonstration Project

The three-year CMS Part A to Part B Rebilling Demonstration Project(https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date) began on January 1, 2012 and will continue until December 31, 2014.

The demonstration allows a limited number of participants, 380 hospitals, with Medicare inpatient claims denied during the audit process because the services were determined to be provided in the incorrect setting, to resubmit the entire claim for outpatient reimbursement. Under current RAC rules, these inpatient denials can receive corrected payment only for ancillary outpatient costs rather than full outpatient costs, which results in a material underpayment to hospitals and an overpayment to the RACs.

Under the "rebilling" demonstration, 380 hospital participants are able to receive 90 percent of the Part B payment for Part A inpatient short stay claims that have been denied by a RAC, MAC or Comprehensive Error Rate Testing (CERT) contractor on the basis that the inpatient admission was not reasonable and necessary. Participants may also self-identify improper claims, cancel the original claims and resubmit a new claim for outpatient reimbursement.

In order to participate in the demonstration project, hospitals had to waive their appeal rights for all short stay claims that are denied because a CMS auditor determined the care should not have been provided in the inpatient setting.

The AHA is disappointed that CMS will not allow *all* hospitals in the nation to rebill and that the agency has chosen to continue to underpay hospitals for medically necessary care provided to Medicare patients. Furthermore, the AHA has major concerns with the demonstration requirement that hospitals waive all appeal rights for these claims.

For more information, see AHA's Advisory on the demonstration project (http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2011/111212-regulatory-adv.pdf).

Underpayments

A RAC reviews 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 reviews each claim line or payment group and considers 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 identifies 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 also can be found upon completion of a complex review. A subsequent review results letter may communicate such findings and 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.

Extrapolation

A RAC may use extrapolation, but only in situations where there is a sustained or high level of payment error or when documentation shows that the carrier/FI/MAC educational interventions have failed to correct the payment error. If a RAC proposes to use extrapolation, that methodology will undergo new issue review and approval before proceeding. Information on the process and methodology the RACs must use for extrapolation can be found in section 3.10 of the *Medicare Program Integrity Manual*. A RAC will receive its full contingency fee for extrapolated claims.

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.

Preventing Duplicative Audits

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 ZPICs or the OIG.

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 is updated on a regular basis by several Medicare contractors conducting provider audits.

Claims are “excluded” when they have already been reviewed by another entity such as the Medicare contractor (FI, 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.

Additionally, CMS temporarily prohibits RACs from reviewing claims that are under review for potential fraud by CMS, 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.

Provider self-audits. If a provider conducts a self-audit and identifies an improper payment(s), the provider is mandated by federal law to report the improper payment(s) to CMS within 60 days of identification. (For more information, see the Self-Reporting Improper Payments section on page 21 of this advisory.) 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.

Medicare Beneficiary Liability

When the RAC identifies an improper payment, the provider participation agreement indicates that the provider is responsible for returning the cost sharing amount collected and the reimbursement collected from the patient or the secondary payer.

In certain instances, when an overpayment is identified, the hospital may hold the beneficiary liable for non-covered services. Review the CMS RAC Statement of Work for more information. For additional information, including examples of the documents issued to Medicare beneficiaries, visit the CMS Beneficiary Notices Initiative website (http://www.cms.gov/BNI/). Also, check the *Medicare Claims Processing Manual*, Chapter 30 – Financial Liability Protections (http://www.cms.gov/manuals/downloads/clm104c30.pdf)

RAC Prepayment Review Demonstration Project

The permanent RAC program limits contractors to post-payment review; however, CMS plans to allow RACs in 11 states (California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania and Texas) to begin pre-payment review of provider claims under the RAC Prepayment Review Demonstration Project (https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&%20srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date). The demonstration is scheduled to begin in Summer 2012 and end in December 2014, but CMS could elect to continue the demonstration and also to expand it to all states.

While CMS has yet to release details of the demonstration, the agency indicates that the initial focus of the pre-payment reviews will be on inpatient hospital claims, particularly short stays and "payment determinations will be made following the same processes with which providers are familiar." CMS will use multiple data sources to develop specific targets and will instruct RACs to conduct pre-payment reviews of specific types of claims. RACs will review the claims and may deny payment before it is made. Contingency fees for the RACs and administrative costs will be paid out of funds that CMS saves by denying claims. Current Medicare RAC program appeal rights will apply.

According to CMS, seven of the demonstration states (California, Florida, Illinois, Louisiana, Michigan, New York and Texas) were chosen based on their high level of fraudulent claims and four states (Missouri, North Carolina, Ohio and Pennsylvania) were selected based on having high claim volumes for short inpatient hospital stays. States from each of the four RAC regions are included in the demonstration project.

CMS elected to delay the implementation of the demonstration from January to June 2012 after hearing concerns from the AHA and other provider groups. A second delay was recently announced and CMS is planning implementation during the summer of 2012. The AHA continues to urge CMS to adopt appropriate restrictions on the program to avoid duplicative audits and the inappropriate denials, process problems and lack of transparency currently associated with many of the agency's other auditing programs.

Monitor CMS's RAC website for updates on the demonstration:
http://www.cms.gov/Recovery-Audit-Program/01_Overview.asp#TopOfPage

Medicaid RACs

The ACA required each state Medicaid program to contract with one or more RACs to identify underpayments and overpayments to Medicaid providers and recoup overpayments. States were required to contract with at least one Medicaid RAC by January 1, 2012. According to CMS, providers can expect Medicaid RAC provider audits to begin, if they haven't already, no later than Summer 2012.

States may apply for exemptions from the program, and, as urged by the AHA, states may exclude Medicaid managed care claims from RAC review. CMS issued a final rule http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf for the program on September 14, 2011 that addressed many of the AHA's concerns by adopting several RAC restrictions that will more closely align the Medicaid RAC program with the Medicare RAC program, protect providers and reduce the administrative burden associated with the program. The rule requires Medicaid RACs to:

- Set limits on the number and frequency of medical records to be reviewed;
- Employ trained medical professionals and at least one medical director;
- Provide appeal rights under state law or administrative procedures;
- Notify providers of overpayment findings within 60 days;
- Develop a provider education and outreach program that includes notification of audit policies and protocols;

- Provide a toll-free customer service telephone number and staff the number during normal business hours;
- Compile and maintain provider-approved addresses and points of contact; and
- Accept electronic medical records on CD/DVD or via fax.

For more information on the Medicaid RAC Program, see the AHA Medicaid RAC Final Rule Advisory http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2011/111017-regulatory-adv.pdf and a FAQ document CMS issued in January 2012 (http://www.cms.gov/MedicaidIntegrityProgram/downloads/Scanned_document_29-12-2011_13-20-42.pdf). Hospitals should share the advisory and FAQ document with their senior management team and hospital utilization review, coding and billing staff, as well as clinical leadership team, to apprise them of the new program. Hospitals should develop a plan to respond to Medicaid RAC inquiries and take corrective actions to limit vulnerabilities.

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 needs improvement. We continue to encourage CMS and Congress to make additional changes to improve the program.

Since the inception of the RAC program, the AHA has engaged in numerous education efforts to assist hospitals in reducing their vulnerabilities to RAC audits, including recent webinars on the appeals process and live conversations with CMS RAC officials and representatives from your region's RAC (http://www.aha.org/advocacy-issues/rac/educational.shtml).

This Spring, we began ***AHA's Audit Education Series***, consisting of several free educational webinars and resources designed to assist members in reducing vulnerabilities to government auditors. During the series, auditing experts will guide participants through the maze of auditing programs and share strategies on how to improve payment accuracy. The series also will examine the pitfalls of medical necessity review and provide advice on how to avoid these costly denials.

Finally see the advisory, Reducing Vulnerabilities to Payment Denials, for strategies and resources to reduce your vulnerabilities to program integrity auditors. Visit www.aha.org/rac for additional AHA member resources.

FURTHER QUESTIONS

Please contact Don May, vice president of policy, at (202) 638-1100 or e-mail RACinfo@aha.org.