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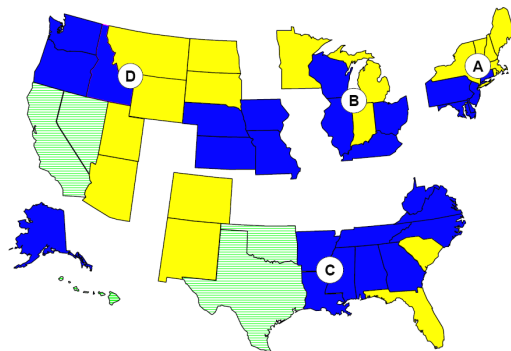
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1. What is a RAC?

The Recovery Audit Contractor (“RAC”) program was initiated by the Centers for Medicare and Medicaid Services (“CMS”) to “detect and correct improper payments” made by the Medicare program to providers. For the RAC program, CMS provides the RACs, the private entities under contract with CMS, with Medicare claims data for the targeted providers. Using this Medicare claims data, the RACs use data mining techniques to identify possible payment errors. Unlike any other CMS audit program, RACs are paid for their services on a contingency fee basis.

The RAC program started in 2005 as a three (3) year demonstration project limited to five (5) states. The RAC demonstration project cost CMS approximately 20 cents for every dollar collected, which covered both administrative costs and the contingency fee payments to the RACs. Based in part on the demonstration project’s financial success, Congress directed that the RAC program be expanded to all states by January 1, 2010 and, while it is unclear if the RACs will begin auditing in all states by January 1, 2010, CMS has begun phasing in the expanded program.

For the expanded program, CMS divided the country into four (4) regions: A, B, C and D, and used a competitive bidding process to select a RAC for each region. The regions are as follows:



2. Which RAC covers my region and what is the web address for my RAC?

The RAC for Region A is Diversified Collection Services, Inc. (www.dcsrac.com); the RAC for Region B is CGI Technologies and Solutions, Inc. (<http://racb.cgi.com>); the RAC for Region C is Connolly Consulting Associates, Inc. (www.connollyhealthcare.com/RAC); and the RAC for Region D is HealthDataInsights, Inc. (<http://racinfo.healthdatainsights.com>). See FAQ 5 for information regarding the specific issues each RAC will audit.

3. What type of reviews do RACs conduct and what do RACs rely upon in conducting their reviews?

RAC audits consist of two types of reviews: (1) automated reviews, and (2) complex reviews.

Automated Reviews. For automated reviews, RACs use data mining techniques to identify obvious payment errors, such as the submission of a duplicate claim for the same service. For automated reviews, no medical records are requested from the provider. The RAC simply forwards its overpayment demand letter to the provider. The demand letter must set forth the rationale upon which the RAC made its overpayment determination, including the particular coverage/coding/payment policy that was violated.

Complex Reviews. For complex reviews, RACs, using data analyses, determine that a payment error “likely” occurred. The RAC then requests medical records from the provider in order to conduct a more in-depth review before making a determination as to whether an overpayment or underpayment actually occurred.

Regardless of the review type, RAC auditors may only rely on Medicare policies, regulations, national coverage determinations, local coverage determinations and manual instructions in making their determinations. In instances where there is no Medicare policy, RACs may rely on “accepted standards of medical practice” that existed at the time of claim submission. RACs are not authorized to develop or apply their own coverage, coding or billing policies.

4. When will RAC reviews begin in my state?

Based upon the designation of each state as yellow, green or blue as depicted in the graph under Question 1, CMS has published the following phase in schedule:

CMS RAC Review Phase-in Strategy

as of 06/24/09

Earliest possible dates for reviews in yellow/green states	Earliest possible dates for reviews in blue states
<ul style="list-style-type: none"> • Automated Review- Black & White Issues (June 2009) • DRG Validation- complex review (Aug/Sept 2009) • Complex Review for coding errors (Aug/Sept 2009) • DME Medical Necessity Reviews- complex review (Fiscal year 2010) • Medical Necessity Reviews- complex review (calendar year 2010) 	<ul style="list-style-type: none"> • Automated Review- Black & White Issues (August 2009) • DRG Validation- complex review (Oct/Nov 2009) • Complex Review for coding errors (Oct/Nov 2009) • DME Medical Necessity Reviews- complex review (Fiscal year 2010) • Medical Necessity Reviews- complex review (calendar year 2010)

5. Are RACs restricted on the specific issues they can review?

Yes. RACs may only review claims for issues that have been pre-approved by CMS. Once approved by CMS, the approved audit issues must be published on the RAC’s website.

Below is the website for each RAC’s list of approved issues:

Region A: Diversified Collection Services, Inc. <http://www.dcsrac.com/issues.html>

Region B: CGI Technology and Solutions, Inc. <http://racb.cgi.com/Issues.aspx?st=1>

Region C: Connolly Consulting Associates, Inc.
http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

Region D: HealthDataInsights, Inc.
<https://racinfo.healthdatainsights.com/Public/NewIssues.aspx>

The RACs are constantly updating their lists of approved issues, thus it is important to frequently review your RAC's issue list.

6. *Other than the requirement that RAC issues be pre-approved by CMS, what are some of the other limitations placed on RAC reviews?*

Claim Dates Subject to Review. RACs may only review claims paid on or after **October 1, 2007**.

Look Back Period Allowed. RACs may only look back **three (3) years** from the claim payment date, subject to the above-referenced October 1, 2007 date. This means the RAC's initial medical record request must be sent to the provider within three (3) years from the date the claim was originally paid.

Medicare Benefit Program Claims Subject to Review. RACs may only review claims that are submitted under a Medicare fee-for-service plan. Thus, claims submitted to Medicare Advantage Plans or as part of the Medicare prescription drug benefits program are not subject to review.

Specific Claim Types Exempted From Review. RACs may not review:

- (1) payments made under CMS demonstration projects;
- (2) claims previously reviewed by another Medicare contractor; or
- (3) claims involved in a potential fraud investigation.

7. *Are physicians involved in the RAC review process? What are the credentials of those individuals making RAC review determinations?*

Each RAC is required to employ a full-time physician as Medical Director to oversee the medical record review process. With regard to specific reviews, medical necessity reviews must be conducted by a registered nurse or therapist as applicable, and all coding determinations must be made by certified coders.

8. *Is there a limit on the number of medical records a RAC can request from a provider?*

Yes. CMS has placed limits on the number of medical records a RAC can request from a particular provider. For FY 2009, CMS issued the following medical record limitations:

Provider Type	Limit on Medical Records Requested With 45 Days
Inpatient hospital Inpatient Rehabilitation Facility Skilled Nursing Facility Hospice	10% of average monthly Medicare <u>claims</u> (maximum of 200) per 45 day period <u>Example.</u> Community Hospital with 1,200 paid claims in 2007 would have an average of 100 Medicare claims paid per month (1,200 divided by 12=100). 10% of this 100 record average is 10. Thus, a RAC is limited to requesting 10 medical records per 45 days.
Outpatient Hospital Home Health Other Part A Billers	1% of monthly Medicare paid <u>services</u> per 45 days (maximum of 200) per 45 day period. <u>Example.</u> Home Health company with 1,500 Medicare paid services in 2007 would have an average of 125 Medicare paid services each month (1,500 divided by 12=125). 1% of this 125 average is 1.25. Thus, the RAC is limited to requesting 2 records per 45 days.
Physicians	<u>Sole practitioner:</u> 10 records/45 days <u>Partnership of 2-5:</u> 20 records/45 days <u>Group of 6-15:</u> 30 records/45 days <u>Group of 16+:</u> 50 records/45 days
Other Part B Billers (IDTFs, DME, Ambulance, Labs)	1% of monthly Medicare paid <u>services</u> per 45 days (maximum of 200) per 45 day period. <u>Example.</u> DME company with 360,000 Medicare paid services in 2007 would have an average of 30,000 Medicare paid services each month (360,000 divided by 12=30,000). 1% of this 30,000 average is 300. Thus, the RAC is limited to requesting 200 records per 45 day period because the maximum number of records is capped at 200.

CMS has not issued revised medical record request limits for FY 2010 and has indicated that, to date, the request limits posted for FY 2009 are in effect.

9. Are providers permitted to submit medical records electronically?

RACs are required to accept medical records in both paper format, as well as records imaged to CDs or DVDs. In 2010, RACs are required to develop a system to allow providers to directly transmit records electronically to the RACs.

10. What address and contact information does the RAC use in correspondence with providers?

RACs will use the provider's address and contact information maintained by the Medicare contractor that processes the provider's claims. However, providers may contact their RAC and provide a specific address and/or contact person for all correspondence from the RAC.

11. Do RAC reviews replace other types of CMS audits, such as CERT audits?

RAC audits do not replace any existing CMS audit programs. Rather, RAC audits are in addition to other CMS audits already in effect, such as the Comprehensive Error Testing Program or Quality Improvement Organization reviews.

12. What types of providers have RACs historically focused on and what were the bases for denying claims?

Because the RAC program is in the early stages of implementation, there is no data currently available on the types of entities RACs are focusing on or the bases for denials. However, in the three (3) year, five (5) state demonstration project, a majority (91%) of the overpayments identified involved inpatient provider claims, including inpatient hospital and rehabilitation providers. The basis for the majority of the overpayment determinations (75%) was a lack of medical necessity or incorrect coding.

13. Will RACs focus on radiology and imaging services?

Radiology and imaging services were available for RAC review during the three (3) year, five (5) state demonstration project. As the expanded fifty (50) state program is implemented, RACs may focus on radiology and imaging services.

14. How is a provider notified that a RAC is conducting an automated or complex review of the provider? What is the deadline for submitting medical records? How long will it take before I receive the RAC's decision?

For automated reviews, which do not involve any medical record review and are limited to identifying obvious payment errors, providers are only notified if the RAC identifies an overpayment or underpayment. If no overpayments or underpayments are identified, the provider will receive no information from the RAC.

For complex reviews, which begin with data mining to identify “likely” payment errors, the RAC will send a medical records request to the provider. The provider must provide the requested medical records **within 45 days**. Although a provider may request an extension of time from the RAC, the request must be made prior to the deadline for submitting the medical record. A RAC must complete a complex review **within 60 days** from receipt of the medical record documentation unless the RAC obtains a waiver from CMS granting an extension to this deadline.

Regardless of whether an overpayment determination results from an automated or complex review, a demand letter is issued by the RAC, which must point to the particular coverage/coding/payment policy violated. In addition, for complex reviews, the RAC must also inform the provider of cases where no improper payment was identified. Following receipt of the RAC's demand letter, the provider has two options: (1) to submit the overpayment or allow recoupment of the overpayment; or (2) to refute the overpayment determination.

15. What are the provider's rights if the provider does not agree with the RAC's determination?

Providers may appeal RAC determinations. The appeals process for RAC determinations is similar to the regular five (5) level Medicare appeals process. Below is a summary of the five (5) levels of appeal:

- **Level 1: Redetermination to Medicare contractor**
 - 120 days to file (recoupment of the overpayment may begin at day 41 unless appeal filed)
 - Decision must be rendered within 60 days.
- **Level 2: Reconsideration to Qualified Independent Contractor**
 - 180 days to file (recoupment of the overpayment may begin at day 61 unless appeal filed)
 - Decision must be rendered within 60 days.
- **Level 3: Administrative Law Judge**
 - 60 days to file
 - Decision must be rendered within 90 days.
- **Level 4: Medicare Appeals Council**
 - 60 days to file
 - Decision must be rendered within 90 days.
- **Level 5: Federal District Court**
 - Final level of appeal
 - 60 days to file

While a provider is allowed 120 and 180 days, respectively, to file its first and second level appeals, CMS will begin recouping the alleged overpayment on days 41 and 61, respectively, unless an appeal is filed. For subsequent levels of appeal, filing the appeal does not delay CMS' recoupment of the alleged overpayment.

A provider may only submit additional medical records or other documentation for consideration during the first two levels of appeal. Thereafter, additional medical records or other documentation may only be submitted if the provider shows there was "good cause" for failing to submit the documentation during the earlier levels of appeal.

In addition to this formal appeals process, each RAC has a “rebuttal” process. As part of the rebuttal process, providers may submit a response to the RAC’s demand letter within 15 days of the date of the demand letter describing why the overpayment should not be recouped. A response to the rebuttal letter must be provided within 15 days of its receipt. This rebuttal process does not change the formal appeal deadlines.

16. *Is there any data available on the success of appeals?*

The most recent statistics from CMS indicate that providers appealed 22.5% of the RAC overpayment determinations. Of those claims appealed, a decision was made in favor of the provider in 34% of the cases, although most were overturned in the later stages of appeal. Detailed appeal information is available on CMS’ website at <http://www.cms.hhs.gov/RAC/Downloads/AppealUpdateThrough83108ofRACEvalReport.pdf>.

17. *Where can I find additional information about RAC audits?*

CMS’ website contains a dedicated section for RAC information at <http://www.cms.hhs.gov/RAC/>.