ACG GI Practice Toolbox

Medicare Compliance and Preparation for RAC Audits

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INTRODUCTION:

The Centers for Medicare and Medicaid Services (CMS) has taken the next steps in Medicare's comprehensive efforts to identify improper payments and fight fraud, waste and abuse in the Medicare program by awarding contracts to Recovery Audit Contractors (RACs). The basis of these regional RACs was a successful federal demonstration project involving six states. That project produced significant recovery results by identifying improper payments by CMS providers, and as a result, the program was implemented nationwide. Preparing your practice for these audits is a high priority project.

TOPIC OVERVIEW:

The goal of the recovery audit program is to identify improper payments made on claims for health care services provided to Medicare beneficiaries. This is done on a post-payment review. The claim processing contractors are the entities responsible for adjusting the claim, handling collections (offsets and checks) and reporting the debt on the financial statements. Believe it or not, underpayments are to be identified as well and additional revenue paid.

Overpayments occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies. Underpayments occur when health care providers submit claims for a simple procedure but the medical record reveals that a more complicated procedure was actually performed. RACs will only be able to look back three years from the date the claim was paid.

The contractors are paid on a contingency fee basis for both overpayments and underpayments they find. Needless to say, the RACs have a huge incentive to find overpayment and underpayments. That percentage would allow them to generate significant revenue over the next few years. Don't assume that you won't have to worry about RACs. If they continue to be successful, there is no doubt everyone will have a RAC audit sooner or later. In almost every practice, a RAC can find some billing, coding, or documentation issue during any given audit.

Medical practices may occasionally benefit from a RAC audit. In practices where physicians have been consistently coding at low levels for almost all services they provided, underpayments may be reimbursed. If such a practice is subject to a RAC review, they should get money back.

The flip side could be much worse. If a practice is found to be consistently coding at a higher level than the documentation supports, then RAC will require repayment to the appropriate level of service. Training providers in your practice on documenting correctly for code levels will help avoid the cost of overpayment in the future. It is wise to have a system in place through a compliance plan and documentation training to help decrease the risk of an audit or overpayments. It is not a matter of "if" but, "when" in regards to auditing medical practices.

Almost everyone will be affected by an audit. Health care providers that might be reviewed include hospitals, physician practices, nursing homes, home health agencies, Durable Medical Equipment (DME) suppliers and any other provider or supplier that bills Medicare Part A and B. The more claims billed to Medicare, the greater the chance of an audit. However, don't be fooled into assuming small practices will be excluded.

CMS awarded new fee for service (FFS) RAC contracts on October 31, 2016 to the following businesses:

1. Performant Recovery, Inc., in Region 1
2. Cotiviti, LLC**,** in Region 2
3. Cotiviti, LLC, in Region 3
4. HMS Federal Solutions, in Region 4
5. Performant Recovery, Inc., in Region 5

The RAC employs a staff consisting of nurses, therapists, certified coders and a physician Contractor Medical Director (CMD). They are obviously concerned with how much money is being paid by Medicare and are encouraged to recover as much as possible. Since the contractor is paid a percentage of money recovered, they are incentivized to find these mistakes.

The RAC will review claims on a post-payment basis and will use the same Medicare policies as the carriers. Issues identified by the RAC will be submitted to CMS for approval prior to a widespread review. Once an issue receives CMS' approval, the RAC will use its own proprietary software and systems as well as its knowledge of Medicare rules and regulations to determine what areas to review. Contractors use data analysis techniques to identify those claims most likely to result in underpayments or overpayments. This process is called "targeted review."

Types of Compliance Reviews

There are three types of compliance reviews. Automated reviews occur when a RAC makes a claim determination at the system level without a human review of the medical record. Semi-Automated claims review using data and potential human review of a medical record or other documentation. Complex reviews occur when a RAC makes a claim determination utilizing human review of the medical record.

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After receiving the RACs' determination, you have the following options:

1. Pay by check
2. Allow recoupment from future payments
3. Request or apply for extended payment plan
4. Request an appeal according to the allowed timeframes

If an adjustment is needed based on a RAC review, the adjustment, whether overpaid or underpaid, will be indicated on the explanation of benefits called "adjustment based on a recovery audit." This will allow providers to know that the claim was adjusted for a particular reason.

An appeal process is outlined on the CMS website. If automated or complex review results in some form of adjustment needed, a provider can initiate a discussion period with the RAC or file an appeal with Trailblazer.

PRACTICAL SUGGESTIONS AND EXAMPLE FOR YOU PRACTICE:

What to do to minimize audit risk:

1. Don't wait: You must make an effort to ensure your group is submitting proper claims.
2. Conduct an internal assessment to identify if you are in compliance with all Medicare coding and documentation rules. It is usually best to hire an outside consultant.
3. Use the claim review to identify corrective actions to promote compliance.
4. Review the findings on an individual basis with providers.
5. Document corrective actions taken.
6. Repeat the review in one year.
7. Appeal when necessary (Often the same consultant for your external billing review can help your practice respond to the audit initial findings and appeal).
8. Check the RAC Web site monthly for new issues and improper payment findings.
9. Identify and implement corrective actions to promote compliance (e.g., initiate awareness in the mailroom, medical records and Medicare billing departments about RAC requests for medical records and be familiar with Connolly Healthcare's envelope logo).

RESOURCES:

1. CMS RAC Audit Website: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/
2. RAC Regional Contracts: http://www.aha.org/advocacy-issues/rac/contractors.shtml
3. RAC Contractor Contact Information: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/NEW-Medicare-FFS-RAC-contact-info12616.pdf

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4. RAC Audit Appeal Process: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Part-D-RAC-Appeal-Process.html
5. Types of Audits: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RACSlides.pdf

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