MEDICARE FEE-FOR-SERVICE RECOVERY AUDIT PROGRAM MYTHS
DECEMBER 17, 2012

- Myth: RACs deny every claim that they review
  - Fact: RACs identify underpayments and overpayments of claims paid under the Medicare program for services for which payment is made under Part A or B of tile XVII of the Social Security Act.
    - This is accomplished through review of all claim and provider types and a review of claims/providers that have a high propensity for error based on the Comprehensive Error Rate Testing (CERT) program and other CMS analysis.
      - Improper payments may result from:
        - Incorrect payment amounts
        - Non-covered services (including services that are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act),
        - Incorrectly coded services (including DRG miscoding)
        - Duplicate services

Below is information from the FY 2012 Comprehensive Error Rate program regarding the length of stay and the projected improper payments. Information like this is used by CMS and the Recovery Auditors to determine what areas to review. Recovery Auditors find errors consistent with the error rates below.

Projected Improper Payment (in Billions $) by Type of Error for DRG Length of Stay

DRG Length Of Stay	Error Rate (%)	Projected Improper Payment (in billions)	Type of Error						
			Insufficient Documentation	No Documentation	Medically Unnecessary	Incorrect Coding			Other
						Overall Incorrect Coding	Over-payment Due to Incorrect Coding	Under-payment Due to Incorrect Coding	
1. <1 day	36.1	$3.43	$0.60	$0.03	$2.62	$0.18	$0.06	$0.11	$0.00
2. 2 days	13.2	$1.56	$0.07	$0.00	$1.36	$0.13	$0.02	$0.11	$0.00
3. 3 days	13.1	$2.03	$0.20	$0.09	$1.60	$0.14	$0.05	$0.08	$0.00
4. 4 days	8.0	$0.96	$0.23	$0.01	$0.53	$0.20	$0.11	$0.10	$0.00
5. 5 days	6.2	$0.62	$0.04	$0.00	$0.45	$0.12	$0.08	$0.04	$0.01
6. >5 days	3.5	$1.91	$0.14	$0.00	$1.20	$0.53	$0.22	$0.31	$0.04

- Myth: RACs have a contingency fee between 30 and 50 percent
  - Fact: Recovery Auditors are paid based on a contingency fee basis. The amount of the contingency fee is based on the amount of money from, or reimbursed to, providers. The contingency fee is a percentage of the

amount of the improper payment. In FY 2009 and FY 2010 the contingency fees ranged from 9.0% - 12.5%. The fee is paid once the money is recouped or refunded, not when the improper payment is first identified. The Recovery Auditor must return the fee if an overpayment/underpayment is overturned at any level of appeal.

- Myth: Every RAC denial is overturned on appeal
  - Fact: The appeals process is a multilevel approach that allows providers to appeal a Recovery Auditor's overpayment determination. This process is exactly the same for all providers who want to appeal a Medicare claim decision.
  - Fact: To date, only 2.4 percent of all 2010 claims collected have been both challenged and overturned on appeal. Health care providers have appealed 8,449 claims to date, which constitutes 5 percent of all claims collected in FY 2010. Monitoring appeals activity is a key part of the Recovery Audit program. CMS will continue to track the Recovery Auditor appeal rates.

- Myth: RAC have non-clinicians conduct review of medical records
  - Fact: Each RAC employs: certified coders, nurses, therapists, and a physician (CMD).
    - A Recovery Auditor Organization chart is submitted as part of the proposal and identifies the number of key personnel and the organizational structure of the Recovery Auditor effort.

- Myth: RAC create their own policies and are not bound by CMS regulations, NCDs, or LCDs
  - Fact: The Recovery Auditor shall comply with all National Coverage Determinations (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, local coverage determinations (LCDs) (formerly called local medical review policies (LMRPs)) and local coverage/coding articles in their jurisdiction. NCDs, LMRPs/LCD and local coverage/coding articles can be found in the Medicare Coverage Data Warehouse http://www.cms.hhs.gov/mcd/overview.asp). Coverage Provisions in Interpretive Manuals can be found in various parts of the Medicare Manuals. In addition, the Recovery Auditor shall comply with all relevant joint signature memos forwarded to the Recovery Auditor by the project officer.
  - Fact: Recovery Auditors are required to comply with Reopening Regulations located at 42 CFR 405.980. Before a Recovery Auditor makes a decision to reopen a claim, the Recovery Auditor must have good cause and must clearly articulate the good cause in New Issue proposals and correspondence (review results letters, ADR, etc.) with providers.

- Myth: RACs can review as many claims as they want from a provider.
  - Fact: CMS continues to work with the provider community to reduce the burden of the review process. In doing so, CMS has limited the look-back period for Recovery Auditor reviews to a maximum of 3 years. This is consistent with CMS' claims re-opening and liability policies. Lastly, CMS has limited the number of additional documentation requests that a Recovery Auditor may request at one time, based on provider size and resources. The CMS continues to work with hospital and medical associations in order to receive and respond to provider concerns and further reduce provider burden.
    - The maximum request amount is per campus. The definition of campus is one or more facilities under the same Tax Identification Number (TIN) located in the same area (using the first three positions of the ZIP code). This is different than the definition used for provider-based status.
    - Each limit is based on the provider's prior calendar year Medicare claims volume.
    - The maximum number of requests per 45 days is 400.

- Myth: RACs don't have physicians on staff
  - Fact: Each Recovery Auditor must employ a minimum of one FTE contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. The CMD FTE must be composed of either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience. More than one individual's time cannot be combined to meet the one FTE minimum.

- Fact: All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the contractor must periodically verify that the license is current. When recruiting CMDs, contractors must give preference to physicians who have patient care experience and are actively involved in the practice of medicine.

- Myth: RACs are focusing complex reviews on Critical Access Hospital claims
  - Fact: Recovery Auditors have not completed any complex reviews on Critical Access Hospital claims.
  - Fact: Complex review occurs when a Recovery Auditor makes a claim determination utilizing human review of the medical record. The Recovery Auditor may use complex review in situations where the requirements for automated review are not met or the Recovery Auditor is unsure whether the requirements for automated review are met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered or where no Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists. Complex copies of medical records will be needed to provide support for the overpayment.

- Myth: RACs do not tell anyone what they are reviewing
  - Fact: CMS requires that issues be posted on the Recovery Auditors' websites, which improves transparency to the public and the provider community. Recovery Auditors post online CMS-approved issues that may trigger a Recovery Auditor review. CMS recently began posting additional information to our website related to Recovery Auditor recoveries on a quarterly basis.
  - Fact: Recovery Auditors are required to give the provider a detailed rational of the improper payment determination. Following any complex review, Recovery auditors are required to issue a detailed "review results" letter to the provider outlining any improper payments identified, along with references supporting the determination.

- Myth: RACs do not issues detailed result letters
  - Fact: The Recovery Auditor shall clearly document the rationale for the determination. This rationale shall list the review findings including a detailed description of the Medicare policy or rule that was violated and a statement as to whether the violation resulted in an improper payment. Recovery auditors shall ensure they are identifying pertinent facts contained in the medical record to support the review determination. Each rationale shall be specific to the individual claim under review.
    - Automated Review – The Recovery Auditor shall communicate to the provider the results of each automated review that results in an overpayment determination. The Recovery Auditor shall inform the provider of which coverage/coding/payment policy or article was violated.
    - Complex Review - The Recovery Auditor shall communicate to the provider the results of every semi-automated and complex review, including cases where no improper payment was identified. In cases where an improper payment was identified, the Recovery Auditor shall inform the provider of which coverage/coding/payment policy or article was violated.

- Myth: RACs do not issue timely denial letters
  - Fact: As of January 1, 2012, the Medicare Administrative Contractors (MAC) began issuing the demand (denial) letter to the providers. This was in an effort to increase the time providers had to respond. Since the accounts receivable and demand letter begins interest accrual, includes appeal rights and begins recoupment timeframes it is imperative that the demand letter be dated the same day as the accounts receivable date.

- Myths: RACs outsource all the medical review to staff in India and the Philippines
  - Fact: Each RAC employs: certified coders, nurses, therapists, and a physician (CMD), all within the United States of America.

- A Recovery Auditor Organization chart is submitted as part of the proposal and identifies the number of key personnel and the organizational structure of the Recovery Auditor effort.
- For a listing of RACs and their locations refer to:
  http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/RAC

- Myths: RACs deny IRF (inpatient rehab facility) claims because the care could have been given in a less intensive setting.
  - Fact: A full denial occurs when the Recovery Auditor determines that: (i.) The submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or (ii.) No service was provided.
  - Fact: A partial denial occurs when the Recovery Auditor determines that: (i.) The submitted service was not reasonable and necessary, or (ii.) The submitted service was upcoded (and a lower level services was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made. (iii.) The AC failed to apply a payment rule that caused an improper payment (e.g. failure to reduce payment on multiple surgery cases).

- Myths: RACs target providers who are part of CMS demonstrations
  - Fact: Unless otherwise directed by CMS through technical direction, the claims being analyzed for this award will be all fee-for-service claims processed in Region _ regardless of the providers' or suppliers' physical location.
  - For a listing of RACs and their corresponding Regions refer to:
    http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/index.html?redirect=/RAC

References:

United States Department of Health & Human Services. Centers for Medicare and Medicaid Services. *Statement of Work for the Recovery Audit Program.* 2011.

United States Department of Health & Human Services. Centers for Medicare & Medicaid Services. *Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services.* FY2010 Report To Congress As Required By Section 6411 Of Affordable Care Act. 2011.