

Physicians – Is Your Practice RAC Ready?

RACs – What Are They?

The CMS Recovery Audit Contractor (RAC) permanent program will begin in 2009. The RAC program, which began in 2005 as a demonstration project, uses contingency-fee contractors to detect and recover improper payments in previously paid claims. The 3-year demonstration project identified over \$1 billion in overpayments and is expected to be expanded in scope as the full rollout begins in 2009.

What is the Process?

The RACs perform data analysis to identify areas of high risk potential. Claim history information will be requested from the carriers/intermediaries/MACs and will be utilized by the RACs to identify which records they will request from providers. They RACs will review claims data and records to identify and recover claims overpayments. Providers will be provided an opportunity to appeal negative determinations.

WHAT SHOULD YOU DO?

1. Make sure your documentation is complete. If you have not done so already, review a sampling of your records to ensure:
 - a. Documentation is where it should be
 - b. It is legible
 - c. Documentation supports the services billed.
 - d. Medical necessity is documented within the record
 - e. Chart is signed off with all supporting documentation in the record (lab results, etc)
2. Stay current on regulation changes affecting your practice. Keep your staff current on their knowledge as well. Webinars, audioconferences or seminars with the latest information on regulatory updates affecting E&M documentation, coding, billing and the RACs will keep you ahead of the curve.
3. Begin to watch for the demand letters (automated reviews) and records requests (complex reviews). Once the RAC reviews begin, have a method to track them and respond to them in a timely fashion. Records sent for complex review requests must be submitted within the requested time frame or it will result in automatic denial. You may also choose to review the records (even on a spot check basis) before they are sent.
4. If you receive a letter requesting repayment, review this immediately. If you chose the respond for appeal, this must also be done within a specific time frame. If you are not going to appeal, repayment or payment plan be made within 30 days. These should also be tracked.
5. Know the Medicare appeal process:
 - a. First Level – Appeal negative determination to the MAC (60 days to determine)
 - b. Second Level – Appeal to Qualified Independent Contractor (60 days to determine)
 - c. Third Level – Appeal to Administrative Law Judge (60 days)
 - d. Fourth Level – Appeal to Department Appeals Board (three judge panel issues within 90 days)
 - e. Fifth Level – Appeal to Federal District Court

You should be tracking claims through all levels of the appeals process as well.

Remember that as the above process is occurring that records will continue to be requested every 45 days. So the requests will continue regardless of how many are in any stage of the process. Tracking requests throughout all phases will be key to keeping track of timing and ensuring that all deadlines are met in a timely fashion.