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Recovery Audit Contractors Seen as New Way to Identify Overpayments

CMS Set to Review List of Cases Selected for Audit Before Records Are Requested

The Centers for Medicare and Medicaid Services (CMS) recently announced its intention to pilot a program in three states with the highest per capita Medicare utilization rates: California, Florida, and New York. The request for proposals is to be released in November 2004 with implementation early in 2005.

The three-year "Demonstration Project for Use of Recovery Audit Contractors" (RACs) represents a new approach toward identifying and recovering overpayments to Medicare Part A, Part B, and DMERC providers that is required as a result of the passage of the Medicare Modernization Act.

Details of the project are not final, but a general outline has emerged: designated "recovery auditor contractors," which could be multiple contractors within each state, will identify incorrect payments made to Medicare providers, work to collect overpaid funds, and support CMS through any subsequent appeals. In return, they will receive a percentage of the recovered funds.

Organizations not eligible to bid, either directly or indirectly, for the RAC contracts include fiscal intermediaries (FIs), carriers, Program Safeguard Contractors (PSCs), Coordination of Benefits Contractors (COBCs), and DMERCS.

SELECTION AND AUDIT

"Targeted review" data analysis techniques will be used by the RACs to identify claims likely to reveal overpayments upon audit. In order to avoid situations where the RACs and affiliated contractors are reviewing the same issues or cases, current fiscal year claims, claims more than four years old, claims involving certain CPT codes, and claims for which the beneficiary is respon-



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sible for payment are ineligible for RAC review.

CMS, working with the Office of Inspector General (OIG) and the affiliated contractors, will review a list of cases selected for audit before records are requested to ensure that a provider is not already under investigation or the cases has not previously been reviewed.

Automated review of claims data by the RAC may be performed only when there is “certainty” that a service is ineligible for coverage. “Complex review,” *i.e.*, review of the medical record and other pertinent documentation by a nurse, physician, or other licensed health care professional, will be performed when there is “high probability” that a service is ineligible. Providers are expected to be reimbursed at the Medicare rates used by CMS for any medical records requested for off-site review by the RAC.

Any overpayment determinations by the RAC must be supported with solid evidence and reflect existing national coverage decisions (NCDs), local coverage decisions (LCDs), and other pertinent regulations. Denials for minor omissions, like undated or unsigned orders, are prohibited.

RECOVERY

When an overpayment is identified, the RAC will issue a demand letter to the provider, who will be instructed to remit payment to a lockbox or similar facility and simultaneously advised of provider appeal rights and procedures.

Interest will accrue from the date of final determination. The RAC may offer in-

stallment terms of up to 12 months; other repayment proposals will be referred by the RAC to CMS for further consideration. The RAC, however, may not settle with a provider. Settlement proposals will be submitted to CMS for evaluation; if CMS accepts, contingency fees to the RAC will reflect the settlement amount.

If payment is not made within 120 days, the RAC will send a second, “intent to refer” letter. After 180 days, the RAC will report the unpaid claim to CMS for mandatory cross-servicing through the Treasury Department’s Treasury Offset Program.

If a provider voluntarily self discloses an overpayment, after the RAC’s request for medical records, the RAC will receive a discounted contingency fee.

APPEALS

Should a provider appeal an overpayment determination, the collection process is suspended, and interest does not accrue during this period until the first-level appeal is completed. Appeals resolved in favor of the provider are closed, and contingency fees that may have been paid by CMS to the RAC are returned. If an overpayment determination is upheld, recovery efforts continue through transfer to the Treasury Department.

Underpayments

Claims in which underpayment is apparent will be reported by the RAC to CMS every 30 days. At this point the RAC involvement ends, and no fee is collected.

Final details of the pilot program, when available, will be posted to the Web site www.fedbizopps.gov.

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