

June 2016

### Updates to the Recovery Audit Program

The Medicare Part B fee-for-service Recovery Audit Program was established under Section 1893(h) of the Social Security Act to identify improper payments made to Medicare providers. The program identifies overpayments and underpayments with the goal of implementing processes to reduce improper payments in the future. The Program was mandated to include all states by January of 2010. As of September 2012 a prepayment review was also implemented to decrease the number of overpayments.

#### Know your RAC

The nation is divided into four regions, with a different Recovery Audit Contractor (RAC) responsible for each region. These contractors are selected through a bidding process. As of June 2, 2016 CMS posted the following [important dates and information](#) for the current bidding cycle and transition to the new RAC selections.

- **May 16, 2016** - the last day that a Recovery Auditor could send Additional Documentation Request (ADR) letters or semi-automated notification letters
- **July 29, 2016** - the last day that a Recovery Auditor may send notification of an improper payment to providers. This includes sending a review results letter or no findings letter, and/or providing a portal notification to each provider.
- **August 28, 2016** - Recovery Auditors will complete all discussion periods that are in process by this date. Recovery Auditors continue to be required to hold claims for 30 days, starting with the date of the improper payment notification (via letter or portal) to the provider, to allow for discussion period requests.
- **October 1, 2016** - the last day a Recovery Auditor may send claim adjustment files to the MACs.

Providers may still receive some correspondence related to the current Recovery Auditors while CMS transitions to the new contracts. However, at no time will providers have to respond to ADRs more frequently than every 45 days, or from two different Recovery Auditors. Once the new RACs have been selected, the activities listed above will continue under the newly assigned RAC.

Providers should contact [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov) for questions concerning the transition. The Centers for Medicare and Medicaid Services (CMS) will continue to update this [Website](#) with more information on the procurement and awards as information becomes available.

Though the contractor for your region may change soon, for now any questions should be sent the contractor currently listed for your region. The current RACs with links to their contact information are:

## Timely Topics

### PAYMENT AND PRACTICE MANAGEMENT

Region A – [Performant Recovery](#) (CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT)

Region B – [CGI Federal, Inc.](#) (IL, IN, KY, MI, MN, OH, WI)

Region C – [Cotiviti Healthcare \(Connolly\)](#) (AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV)

Region D – [HealthDataInsights, Inc.](#) (AL, AZ, CA, HI, ID, IO, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY)

For concerns regarding RAC audits contact your RAC directly.

#### RAC Audits are a serious business!

All RACs are paid on a contingency basis. While they look for both overpayments and underpayments, they are paid based on a percentage of the recovered overpayments. In fiscal year ending September 30, 2015, \$359.7 million in overpayments were collected and \$81.0 million in underpayments were returned to providers. According to the [FY2015 Agency Financial Report](#), RACs have collected a net of \$8.9449 billion since the start of fiscal year 2010.

In the past, RACs have been limited to a look-back period of three years. However, based on the final rule from CMS for [Reporting and Returning of Overpayments](#) that look-back period is now expanded to 6 years.

#### Be familiar with the latest changes

Recently some changes have been made to provide more information to providers and to improve the RAC experience. Make sure you are familiar with these changes:

1. Effective May 15, 2015 – RACs are required to post more detailed review information on their individual websites. Information posted includes CMS-approved audit issues. Examples of currently approved audits affecting ASA membership are:
  - a. Anesthesia – CRNA Overpaid, This audit was approved by CMS for following states: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and the Virgin Islands. This is an automated review looking for all Anesthesia services that were provided by both the CRNA and Anesthesiologist but may not have paid at the 50% reduced rate for a supervised CRNA.
  - b. Anesthesiologist overpaid This audit was approved by CMS for following states: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and the Virgin Islands. This is an automated review looking for all Anesthesia services that were provided by both the CRNA and Anesthesiologist but may not have paid at the 50% reduced rate for an anesthesiologist supervising a CRNA.

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2. Effective May 15, 2015 – RACs are required to have a physician Contractor Medical Director and are encouraged to have a specialists' panel for consultation. Physicians may discuss identification of improper payments with the Contractor Medical Director.
3. Effective May 15, 2015 – RACs are required to maintain 95% minimum accuracy rating. Failure to do so will result in reduction of Additional Documentation Requests (ADRs) allowed by the RAC.
4. Effective May 15, 2015 – Recovery auditors are required to maintain an overturn rate of less than 10% for first level appeals. Appeals of any RAC audit results follow the same process as other appeals for your Medicare carrier. See the April 2016 Timely Topic on [Appeals](#) for more information. Failure by the RAC to follow the appeals process may result in CMS placing the RAC on a corrective action plan.
5. Effective January 1, 2016 – ADRs from RACs will have adjusted limits based on a provider's "compliance with Medicare rules". Lower ADR limits will apply to providers with lower denial rates, while higher ADR limits will apply to providers with higher denial rates. [ADR limits](#) will be adjusted over time (if applicable) to correspond with the provider's denial rates.

The next steps toward transparency in the RAC process will include:

1. A provider satisfaction survey is being developed to allow provider feedback.
2. CMS will increase public reporting of data via the Recovery Audit Program Report to Congress, to include appeals, quality assurance activities and timeliness standards. The October 15, 2015 report with details regarding RAC activity in fiscal year 2014 can be read [here](#).

#### Future RAC timeline requirements

There are also future changes planned that will affect physicians, including:

1. RACs will have 30 days to complete a complex review and notify the provider, this is a change from the current 60 days.
2. RACs will have to wait 30 days prior to sending a claim to the Medicare carrier for adjustment in order to allow the provider time to request a discussion.
3. RACs must confirm receipt of a provider's written correspondence or discussion requests within 3 business days.
4. CMS will work with the RACs to provide more standardizing of the provider mortals and display reason statement identifiers.

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5. RACs will be required to broaden their review topics to all provider types. In addition the RACs will be required to review certain topics based on referral such as an OIG report.
6. For any new RAC contracts, the RAC will not receive their contingency fee until after the second level of appeal has been determined. Currently RACs are paid immediately upon denial and recoupment of the claim overpayment.

You can read more details about the planned changes [here](#).

#### What's next?

If you become subject to a RAC audit, knowing the processes can help you navigate the audit and any appropriate appeals. Get familiar with your RAC, their webpage and their processes by using the links above.

Visit [CMS.gov](https://www.cms.gov) for more information on the Recovery Audit Program.