Chris Brewer, JD
Poyner Spruill LLP,
Raleigh, North Carolina

HEALTHCARE PROVIDER REIMBURSEMENT

COMPLIANCE AND ENFORCEMENT

July 5, 2011

I. MEDICARE AUDITS

A. PSC Audits: Program Safeguard Contractor

1. PSCs perform various functions, including fraud case development, data analysis, and medical review to support fraud and abuse cases.
2. Upon completion of an audit, PSCs refer all identified overpayments to the Medicare affiliated contractor (MAC), who subsequently sends the provider a demand letter for recoupment of the alleged overpayment.

B. ZPIC: Zone Program Integrity Contractor

1. CMS created ZPIC zones that coincide with the MAC jurisdictions. The new ZPIC program divides the country into seven jurisdictions, and in each jurisdiction, one ZPIC will be responsible for program integrity oversight and functions for all Medicare claims. As such, the ZPICs will replace the PSCs. The ZPIC for North Carolina is AdvanceMed.

C. RAC: Recovery Audit Contractor

1. Congress has made the program permanent and required CMS to expand the program to all 50 states by the end of 2010.
2. The RAC program divides the country into four regions, and each RAC is responsible for identifying overpayments in its region. The RAC for North Carolina is Connolly Healthcare.
3. Unlike PSCs and ZPICs (which are paid a fixed fee), RACs receive contingency fees based on the amount of recovered overpayments. As a result, RACs have a significant incentive to investigate aggressively potential overpayments.

II. REALITY

A. Increased number of government contractors actively trying to identify Medicare and Medicaid overpayments and potential fraud or abuse in federal health programs.

B. Contractors are using sophisticated data mining programs to identify suspect claims.

C. Government has recognized that use of contractors to identify incorrect and potentially fraudulent claims is cost-effective.

D. Healthcare organizations and providers need effective processes to facilitate proactive and reactive steps to prepare for and manage contractor inquiries and disputes.

III. HOT TOPICS

A. Recovery Audit Contractors (RAC Audits)

1. **Origin of the RACs:** Started as a CMS demonstration program and made permanent by law in 2006, the RACs are government-approved bounty hunters of sorts, as they are paid on a contingency basis to review claims payments, detect and collect overpayments, identify and pay underpayments, and implement corrective action. There are four RACs, who are all private firms under contract with CMS on a region by region basis: DCS (for Region A), CGI (for Region B), Connolly Consulting (for Region C, which include North Carolina and our neighboring states), and HealthDataInsights (for Region D). RACs are permitted to review reimbursements to all fee-for-service providers, *but not* payments made under Medicare Part C (Medicare Advantage) or Part D (Medicare Drug Benefit). RAC Audits have been authorized for providers and suppliers in all 50 states. CMS will try to expand the RAC program to include prescription drugs (Part D) by the third quarter of 2011.

2. **Two types of RAC reviews**:

   a. Automated Reviews – for black and white issues not requiring a medical record review. CMS has stated an automated review is only appropriate if there is certainty of an overpayment based on:

      (1) A clear policy (a statute, regulation, National Coverage Determination, coverage provision in an interpretive manual, or Local Coverage Determination that specifies the circumstances under which a service will always be considered an overpayment).

      (2) A medically unbelievable service.

      (3) No timely response is received in response to a medical record request letter. [45 days to respond to a request, can be extended].

   b. Complex Reviews –requires medical record review, high probability, but no certainty of an overpayment.

   c. Examples of types of reviews:

      (1) Automated review examples:

(a) Identifying duplicate procedures on claims performed on a patient on the same day at the same facility.

i) Once in a life time procedures. Don't have these twice!

ii) Blood transfusion units.

iii) IV hydration units.

(b) Identifying erroneous discharge status codes.

(2) Complex review examples:

(a) Verifying the diagnosis code on a claim matches the diagnosis described in the medical record.

i) DRG payment review if only one complication or comorbidity.

(b) Verifying medical necessity for the setting where the service was rendered based on a review of the beneficiary's condition.

3. **Audit Triggers:**

a. **Improper or inaccurate billing**:

(1) High claim rejection rates

(2) High claim recoupment rates

(3) Utilization screens

(4) Higher utilization than neighboring providers

(5) High clinical case mix assignment

(6) Medicare admission patterns

(7) Claim mismatch with medical record

(8) Lengths of stay outside industry norm

(9) Use of data mining

(10) Beneficiary complaints

4. **Physician Focus Areas:**

a. **Evaluation and Management Services** - All evaluation and management services that were billed during a global period,

duplicate claims for evaluation and management services, consultations and evaluation and management services billed with procedures are all potentially reviewable by RAC. **The review of the level of the visit of some E&M services was not included in the RAC demonstration**. CMS will work closely with the American Medical Association and the physician community prior to any reviews being completed regarding the level of visit and will provide notice to the physician community before the RAC's are allowed to being reviews of evaluation and management services and the level of the visit. All evaluation and management services submitted with modifier 24 could be subject to review.

b. **Medical Necessity** - RACs will be reviewing claims for medical necessity. Ensure that your services meet the medical necessity edits found in the National Coverage Decisions. Ensure that the diagnosis is adequately documented in the medical record for the patient. (Example: Procedures to Pharmaceutical J Codes). RAC will be looking for complete documentation of medical necessity to support diagnosis, along with the frequency of services, and that the dosage administered is properly documented with each occurrence, and will also review multiple services on the same date.

c. **Billing for Non-Covered services as covered services** - for example, cosmetic procedures.

d. **Duplicate Claims** - Claims billed and paid twice for the same service.

e. **High Volume Services** - Any CPT code that is billed at a high volume for any provider regardless if a NCD or LCD exists will be subject to review by RAC.

f. **"Incident to"** - RAC will be looking for NP's or PA's who perform new patient services for and bill under the physician's number.

g. **Unbundling of procedures** - RACs can automatically review for unbundled procedures without a chart review. Keep current with NCCI initiative to ensure that the practice is not billing for more procedures than is appropriate. (Example: Billing for unilateral CPT code twice when another CPT code is applicable for bilateral services billed once.

Place of Service Codes - Ensure that the correct place of service is reported. (Example: billing as an office place of service for provider-based clinics).

5. Other overpayments were most commonly found with:

   a. Hospital Inpatient Services

      (1) Wrong setting for surgeries (inpatient v. outpatient) (med. unnecessary)

      (2) Wrong setting for defibrillator implants or treatment for heart failure and shock (med. unnecessary)

      (3) Excisional debridement (improperly coded)

      (4) Respiratory system diagnoses with vent support (improperly coded)

   b. Hospital Outpatient Services

      (1) Neulasta (prescription to reduce risk of infection, chemo) (med. unnecessary or improperly coded)

      (2) Speech therapy, PT and OT (med. unnecessary)

      (3) Infusion services (med. unnecessary)

   c. Inpatient Rehab

      (1) Services post-joint replacement (med. unnecessary)

      (2) Services for miscellaneous services (med. unnecessary)

6. **RAC Process Basics**:

   a. RACs review claims on a **postpayment basis** and use the same Medicare payment policies as Fiscal Intermediaries (FIs), Carriers and Medicare Administrative Contractors (MACs) (NCDs, LCDs & CMS manuals).

   b. RAC reviews will be either:

      (1) *Automated* (no medical record needed)

      (2) *Complex* (medical record required)

   c. RACs must employ a staff consisting of nurses, therapists, certified coders & a physician CMD.

   d. The Recovery Audit Contractors (RAC) will determine which claims to review by using their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

   e. Under the permanent RAC program, the look-back period for claims review will be limited to three years and no claims with a

payment date prior to October 1, 2007, will be reviewed, regardless of the actual start date for the RAC.

7. **RAC Collection Process:**

   a. Basically the same collection process with the RAC program as the carrier, FI and any MAC identified overpayment.

   b. The difference is that the demand letter is coming directly from the RAC.

   c. At that point, the RAC will issue the demand letter and the carrier, the FI, the MAC at an appropriate time will recoup via offset.

   d. Choices after receiving the demand letter:

      Allow recoupment

      Pay by check

      Stop recoupment by filing your appeal

      Sign up for an extended repayment plan

8. **Preparing for a RAC Audit:**

   a. Conduct a pre-audit risk assessment. Maintain compliance with Medicare rules. Look for patterns on your denied claims and take corrective actions to avoid.

   b. Identify and educate key operational personnel throughout the organization.

   c. Be aware of and use the resources available to organizations (from CMS, AHA, AHIMA, the RACs, etc.).

   d. Develop and implement policies and procedures for handling RAC record requests (will likely differ for an automated versus a complex review).

      (1) This includes assigning roles and responsibilities (along with appropriate timeframes for completion) to tasks associated with each review.

      (2) This includes having a means of tracking and documenting the process.

         (a) By RAC request, by outcome.

         (b) This is essential for an organization to be able to implement improvements based on lessons learned.

(3) Have an appeals strategy in place. There are well-defined (and short) timeframes for appealing an adverse RAC determination.

B. Recovery Audit Contractors (RAC Appeals)

1. **The Appeals Process:** To appeal an overpayment determination, a provider must go through a relatively complex and technical process involving five levels of appeal. Each level of appeal has specific time frames in which to file, and failure to follow these time frames may result in the recoupment occurring despite the appeal or in a total loss of appeal rights. For example, even though you as the provider have 120 days after receipt of the demand letter in which to request a redetermination (the first level of appeal), failure to do so within 30 days of the date of the demand letter may result in the recoupment process starting despite a subsequent appeal.

2. **Data on Appeals to Date:** While data regarding the likelihood of successful RAC appeals is still being evaluated by CMS, preliminary data suggests that it may be worthwhile for providers to appeal overpayment determinations. As of August 2008, RAC appeals filed during the three-year demonstration project showed that approximately 34% of such appeals filed resulted in a favorable decision for the provider, and 7.6% of the determinations were overturned entirely on appeal. However, this data may not be representative of the final results because the appeals filed during the demonstration project continue to work their way through the appeal process. CMS will continue to update the appeal statistics until all appeals are resolved. Since the RACs do not get paid if an overpayment determination is overturned at any stage of appeal, it is certainly in the RACs' best interests if providers choose not to appeal their determinations.

3. **Demand Letter:** Once the RAC concludes that you received an overpayment, providers will be sent a demand letter, also known as an initial determination letter, explaining how the overpayment was determined and the amount due. The demand letter will also explain appeal rights and inform providers of how to stop recoupment from occurring. Recoupment is defined as the recovery of outstanding Medicare debt by reducing present or future payments and applying the amount withheld to the indebtedness. Despite language in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") which provides that recoupment will not occur until a decision on reconsideration is rendered, CMS has taken the position that it may recoup alleged overpayments before a request for redetermination or reconsideration has even been filed. *CR Transmittal #R141FM.*

4. **The Five Levels of RAC Appeals:** A general explanation of the five levels of appeal follows: This process is also provided in a flow chart attached as Attachment A.

   a. **Redetermination**. In the event providers wish to appeal an overpayment determination, you must first request a Redetermination from your Fiscal Intermediary ("FI") or Carrier, as the case may be, within 120 days from the date the demand letter is received. However, in order to stop recoupment of the alleged overpayment, providers must file a request for a Redetermination within 30 days from the date of the demand letter; otherwise, withholding will occur on the 41st day. Providers will also be given the opportunity to "rebut" the findings in the demand letter by submitting a statement within 15 days from the date of the demand letter disputing the debt. However, it is important to remember that the rebuttal or "discussion" period is in addition to, not in lieu of, the appeal process. Only a timely and valid request for a Redetermination or Reconsideration, as discussed below, will stop the recoupment process. No minimal monetary amount must be in dispute in order to request a Redetermination.

      In the event a provider requests a Redetermination more than thirty days after the date of the demand letter, recoupment may begin on the 41st day but will stop once a valid appeal is filed. However, any amounts already recouped will be retained and will not be refunded unless the provider is successful in its appeal. Interest accrues on overpayments throughout the appeal process. The FI's or Carrier's decision is usually issued within 60 days from receipt of the Redetermination request. Providers may wish to consider filing an appeal well before the 120 day deadline to prevent recoupment from occurring for cash flow purposes.

   b. **Reconsideration**. Assuming the provider receives a partially favorable or unfavorable decision by the FI or Carrier, the provider has 180 days from the date of receipt of the Redetermination notice, or revised demand letter, to request a Reconsideration by the Qualified Independent Contractor ("QIC"). However, recoupment may occur on the 61st day unless a request for Reconsideration is filed within 60 days of the date of the notice. After recoupment begins, it can only be stopped by a timely and valid appeal. As is the case with Redeterminations, there is no minimal monetary threshold for this appeal. The provider must submit all necessary evidence in support of its appeal. Evidence may be submitted at any time before the QIC issues its decision.

New evidence cannot be submitted at subsequent levels of appeal absent a showing of good cause. There is no hearing at the reconsideration stage; rather, the QIC will conduct an on-the-record review of the written evidence. The QIC is not bound by Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs), or CMS program guidance, but the QIC must give substantial deference to these policies if they are applicable to the particular case. The QIC's decision is usually issued within 60 days from receipt of the Reconsideration request.

c. **Administrative Law Judge Hearing**. If the QIC issues a partially favorable or unfavorable Reconsideration decision, recoupment will begin regardless of whether a provider proceeds to the third level of appeal with an Administrative Law Judge ("ALJ"). A provider has 60 days from the date of receipt of the Reconsideration to file an appeal with an ALJ. However, there must be at least $100 in controversy (this amount will be adjusted annually). The ALJ hearing will most likely be held by video-teleconference or telephone and a provider may also request the ALJ to make a determination based on the record without a hearing. For North Carolina providers, the request for an ALJ hearing should be filed with the Office of Medicare Hearings and Appeals Southern Field Office, located in Miami, Florida. In some cases, the QIC or other Medicare contractor representative may participate in the hearing. The ALJ will generally issue his or her decision within 90 days of receipt of the hearing request.

d. **Medicare Appeals Counsel**. If providers receive an unfavorable decision by the ALJ, they may then appeal to the Medicare Appeals Counsel ("MAC"). The MAC appeal must be filed within sixty days from the date of receipt of the ALJ hearing decision, and no minimal amount is required to be in controversy. The MAC may also decide on its own motion to review an ALJ's decision. The MAC will limit its review to the evidence contained in the record of the proceedings before the ALJ. Upon request, the MAC will give the provider a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. The MAC will generally issue its decision within 90 days from receipt of your request for review.

e. **Federal District Court**. The final stage of appeal is in a Federal District Court. This judicial appeal must be filed no more than 60 days from the date of receipt of the MAC decision or declination to

review. At least $1,000 must be in controversy following the MAC review, and this amount will be adjusted annually.

Navigating the Medicare appeals process, and preventing or limiting recoupment during the early stages of appeal, will require timely responses to notices and careful attention to detail. However, given that over 30% of the RAC appeals filed thus far have resulted in favorable decisions for the providers, it may be worth your effort to invest the time and resources to challenge RAC overpayment determinations.

C. Provider Without Fault:

1. Pursuant to the "provider without fault" provisions set forth in the Social Security Act, a provider is liable for overpayments he or she receives *unless* the provider is found to be without fault.

2. For purposes of the provider without fault provisions, "fault" is defined as: (a) an incorrect statement made by the individual which he knew or should have known to be incorrect; (b) failure to furnish information which he knew or should have known to be material; or (c) with respect to the overpaid individual only, acceptance of a payment which he knew or could have been expected to know was incorrect.

3. As set forth in the Medicare Financial Management Manual, a provider is considered to be without fault if the provider complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming that the payment was correct.

D. Statistical Sampling and Extrapolation:

1. Contractors frequently use statistical sampling and extrapolation to estimate the amount of overpayment. The Medicare Program Integrity Manual contains requirements for contractors using statistical sampling. Whether it is beneficial to engage a statistics expert to challenge the methodology must be evaluated on a case by case basis.

2. If a challenge is successful, ALJs may require the contractors to disregard their extrapolation and only collect overpayments from the specific claims at issue, where they find that the sampling and extrapolation have not been conducted in a manner that was fair to the provider, or that the methodology was not sufficiently documented to allow the provider to evaluate its fairness. If the provider's error rate falls below a certain threshold as a result of the appeal process, some contractors will forego extrapolation and collect only the sample overpayment.

E. Provider Recoupment and Audit Activities: Medicaid Integrity Program

1. **Medicaid Integrity Program:** Created by the Deficit Reduction Act of 2005, the Medicaid Integrity Program (MIP) is CMS's program to review and audit of Medicaid claims through contractors. The contractors performing these audits are the Medicaid Integrity Contractors (MICs) and function as Medicaid claims equivalents to the RACs who review Medicare claims. The Medicaid Integrity Group (MIG) [expected to be renamed "the Medicaid Program Integrity Group" in the near future or MPIG] was created to implement and manage the MIP. MIG includes three divisions:

    a. Division of Medicaid Integrity Contracting (DMIC);

    b. Division of Fraud Research and Detection (DFRD); and

    c. Division of Field Operations (DFO).

2. **Required MIP activities:**

    a. **Review provider actions/data (conducted by Review MICs).**

        (1) The Review MIC for North Carolina is Thomson Reuters.

        (2) The MIG examines all paid Medicaid claims to identify risk areas for overpayments. Then the Review MIC analyzes billing data (data mining) to identify which providers/suppliers have potential billing issues and refers these to the Audit MIC for the particular state.

    b. **Audit claims and identify overpayments (conducted by Audit MICs).**

        (1) The Audit MIC for North Carolina is Health Integrity. The review of the Audit MIC is post-payment. Once a MIC has identified a list of providers/suppliers for audits, this list is circulated to state Medicaid agencies, state and federal law enforcement agencies, and Medicare contractors (RACs and MACs).

        (2) **Audit MICs do not have responsibility for <u>collecting</u> overpayments.** The federal government will take its share of the overpayment directly from the state and the state has the responsibility to recover the overpayment from the provider/supplier.

            (a) Overpayments may be recovered by withholding a provider's (or an affiliate's) billings or payments.

(3) Notification of Audit. A provider/supplier who has been selected to be audited will receive a notification letter from the Audit MIC that contains the following information:

(a) Identifies a Audit MIC contact person;

(b) Provides two-weeks' advance notice of the audit (notice may be longer);

(c) Requests records to be audited by the Audit MIC. The Audit MIC may request the records be sent to the Audit MIC for a "desk audit" or the Audit MIC may review the records at the provider's/supplier's place of business (a "field audit"). At present, most MIC audits are expected to be desk audits.

(4) Conferences with the Audit MIC.

(a) Entrance conference: The Audit MIC will schedule an entrance conference with the provider/supplier to describe the audit's scope and objectives and to provide other relevant information.

(b) Exit conference: After the audit has occurred, the Audit MIC will meet with the provider/supplier to go over preliminary audit findings and to provide the provider/supplier with an opportunity to comment and provide additional information.

(5) Draft Audit Report. If the audit identifies a potential overpayment, the Audit MIC drafts an audit report, which is submitted to CMS and the state for comment and approval. The draft report can be revised with additional information received and is ultimately approved and finalized with overpayment amount fixed by CMS.

(6) Final Audit Report to the State. The final audit report is sent by CMS to the state to serve as official notice to the state of the discovery and identification of an overpayment [42 CFR 433.316(a) and (e)]. Within 60 calendar days of this notice, the state must repay the federal share of the overpayment to CMS [see 42 CFR 433.312(a)]. **The repayment obligation of the state is not affected by**

whether the state collects the overpayment from the provider/supplier (*except if the provider/supplier is determined bankrupt or out of business under the process set forth in 42 CFR 433.318*).

(7) Final Audit Report sent to the Provider by the State. Issuing the final audit report (and overpayment notice) to a provider/supplier is the responsibility of the state. This process is subject to the state's administrative practice act and providers/suppliers have specified rights to appeal or otherwise rights to adjudicate the matter.

(8) North Carolina Results. As of May 2010, DMA reports that 10 providers have undergone MIC audits and no errors have been reported.

c. **Educate providers, plans, beneficiaries, and others on program integrity and quality of care issues (conducted by Education MICs).** There are two Education MICs: Information Experts and Strategic Health Solutions, but they have not yet begun their work.

3. **Comparison between RACs and MICs:**

a. Differences:

(1) MICs are not limited to any lookback period. RACs are limited to 3 years (and no claims before Oct. 2007).

(2) Audit MICs do not have medical record request limitations.

(3) Audit MICs are not paid on a contingency fee basis.

(4) Providers do not have the benefit of the **"provider without fault"** defense to a Medicaid overpayment claim. Under this defense, payment may be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services.

b. Similarities:

(1) Both MICs and RACs review and select providers for audit using algorithms to analyze electronic claim data for aberrancies.

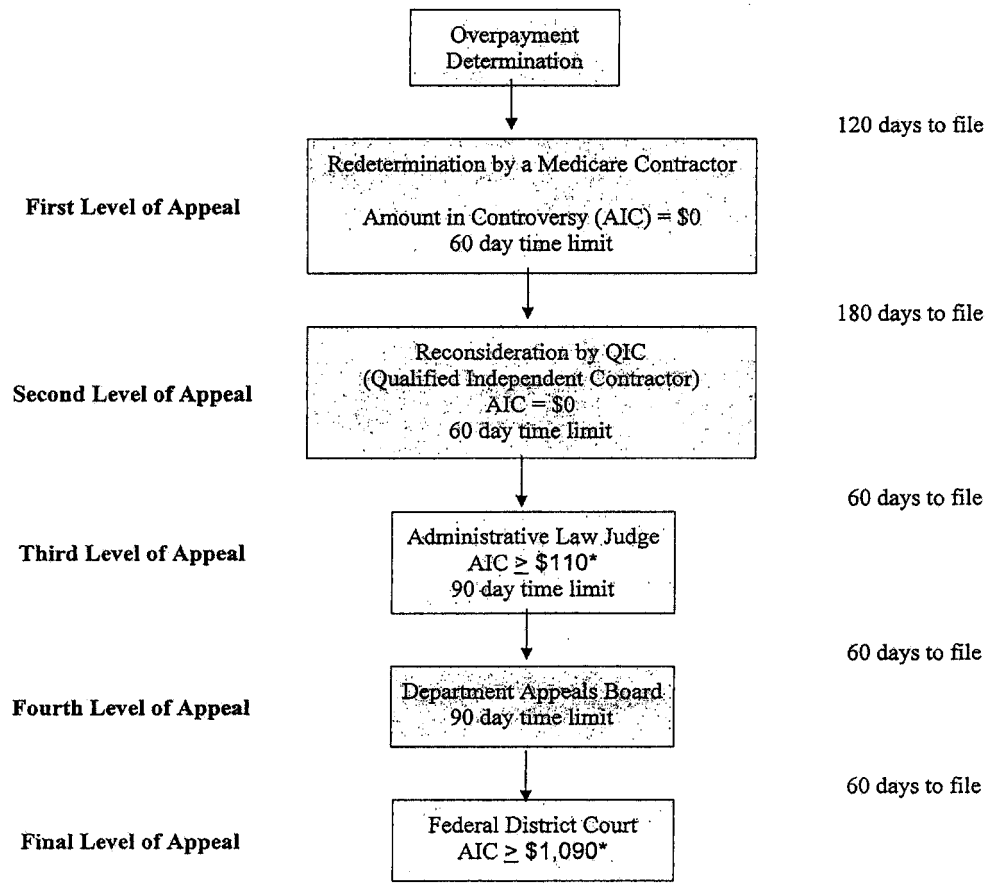
(2) Auditing is post-payment for RACs and MICs.

c. Medicaid records and identified potential fraudulent activity. IBM's project is called the Fraud and Abuse Management System and is offered as part of IBM's Center for Business Optimization. The IBM system can identify potential fraud both before a claim is paid and post-payment.

ATTACHMENT A

RAC APPEALS

Mechanics of the Process



*The Amount in Controversy requirement for an Administrative Law Judge hearing and Federal District Court will be adjusted in accordance with the medical care component of the consumer price index.

Physician/Non-Physician Practitioner Additional Documentation Limits
(As of 02/14/2011)

In response to feedback from the RACs, physicians and their associations,CMS has modified the physician/non-physician practitioner additional documentation request (ADR) limits for the RAC program.

1. The limits will be based on the servicing physician or non-physician practitioner's billing Tax Identification Number (TIN), as well as the first three positions of the ZIP code where that physician/non-physician practitioner is physically located. For example:

   Physician Group ABC has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356. This group would qualify as a **single entity** for additional documentation limit purposes.

   Physician Group XYZ has TIN 123456780 and is physically located in 12345 as well as 21345. This group would qualify as **two** unique entities for additional documentation purposes and each location would have its own additional documentation request limit.

2. ADR limits will be based on the number of individual rendering physicians/non-physician practitioners reported under each TIN/ZIP combination in the previous calendar year.

Group/Office Size	Maximum number of requests per 45 days
50 or more	50 records
25-49	40 records
6-24	25 records
Less than 5	10 records

   Example 1: Group ABC has 65 physicians and non-physician practitioners that billed Medicare fee-for-service claims last year. The group's additional documentation request limit would be 50 additional documentation requests every 45 days.

   Example 2: Group XYZ has 6 physicians and non-physician practitioners in their practice that billed Medicare fee-for-service claims last year, four are located at a clinic in ZIP 12345 and two are at a clinic in ZIP 21345. The maximum additional documentation limit would be 10 additional documentation requests every 45 days, per site.

The CMS reserves the right to give the RACs permission to exceed the cap. Permission to exceed the cap may be granted on CMS's own initiative or upon request by a RAC. Affected physicians/practices will be notified in writing.

At times it may be difficult for a RAC to accurately determine the size of a physician/practitioner group. If a request is received that does not adhere to the above guidelines, the practice should contact the RAC with documentation of the group size. If the number of full time equivalent physicians and non-physician practitioners is significantly different than the number of individual rendering physicians and non-physician practitioners appearing in the RAC's claim data, the group may petition the RAC for a modified limit. Groups may also work with the applicable RAC to establish a point of contact for the entire group, and/or a single mailing address for RAC correspondence. If additional assistance is needed please contact CMS at RAC@cms.hhs.gov.

PROVIDER INTEGRITY PROGRAMS

Program/Contractor/Agency	Function	Recoveries
CMS MEDICARE INTEGRITY		
Medicare Recovery Audit Contractors (RACs)	Review claims for improper payments made under Medicare Parts A or B. The health reform law extends RACs to Parts C and D. They receive a percentage of the overpayments and underpayments they identify.	During RAC Demonstration Project, $1 billion was recovered as compared to operating costs of $.10.
Zone Program Integrity Contractors (ZPICs)	Replaced program safeguard contractors (PSCs). Conduct fraud and abuse investigations of all types of claims in a geographic area (zone).	In early FY 2009, PSCs produced a total of $1 billion in Medicare savings.
Medicare Administrative Contractors (MACs)	MACs are replacing carriers and fiscal intermediaries. They process Parts A and B claims, conduct medical reviews and other audits and process RAC and ZPIC overpayment findings.	MACs coordinate recovery and recoupment of payments identified as improper by other contractors.
Comprehensive Error Rate Testing (CERT) Program	Calculates the national paid claims error rate for all of the Medicare fee-for-service claims paid by MACs.	In FY 2008, error rate was 7.8%, which equals about $24.1 billion in improper payments.
CMS MEDICAID INTEGRITY		
CMS Medicaid Integrity Group (MIG) operates the Medicaid Integrity Program (MIP)	Created by the Deficit Reduction Act (DRA) in 2006 to combat Medicaid fraud, waste and abuse by hiring contractors to review provider activities, audit claims, identify overpayments and educate providers.	In FY 2008, about $344 million in Medicaid recoveries was returned as a result of Medicaid program integrity efforts, the HHS FY 2011 budget request says.

Program/Contractor/Agency	Function	Recoveries
Medicaid Integrity Contractors (MICs)	"Review MICs" mine Medicaid claims data and refer anomalies to CMS and state Medicaid integrity officials. The state checks to see (1) whether the provider is already being audited, and (2) whether the anomaly is due to nuances in the state's payment policies. If neither of those apply, the state gives the go-ahead for CMS to alert the Audit MIC to conduct provider reviews.	With more than 1,000 audits now underway in 39 states, the end of FY2009 (Sept. 30), the MICs had identified about $8.5 million in overpayments and found about $13 million through test audits.
Payment Error Rate Measurement (PERM) Contractors	PERM Contractors randomly select claims to audit in 17 states during a 23-month cycle to set the state's error rate. It reviews the fee-for-service, managed care and eligibility components of Medicaid and the Children's Health Insurance Program.	The combined error rate for the FY 2007 cycle was 10.5%. The combined error rate for the FY 2008 cycle was 8.7%.
Medicare-Medicaid Data Match Project (Medi-Medi)	Matches Medicare and Medicaid claims to determine whether errors or fraud with one program are present in the other program.	Total recoveries unknown.
OTHER FEDERAL AGENCIES		
HHS Office of Inspector General (OIG)	Conducts audits, investigations, evaluations and inspections; recommends corrective actions; refers suspected criminal action; and imposes sanctions, including civil money penalties and exclusion from federal programs.	In FY 2009, OIG efforts resulted in $3 billion in HHS receivables, including civil and administrative settlements for Medicare and Medicaid claims.
Department of Justice (DOJ)	The U.S. attorney's offices under DOJ use Health Care Fraud and Abuse Control funds to support their work combating health care fraud and abuse.	DOJ recovered $2.5 billion in FY 2010 from health care fraud lawsuits brought under the False Claims Act.

Program/Contractor/Agency	Function	Recoveries
STATE INITIATIVES		
Medicare RACs	The health reform law requires states to contract with RACs by Dec. 31, 2010, to identify underpayments and recoup overpayments in their Medicaid programs. States will be able to tailor the RAC activities to their unique Medicaid programs. Proposed regulations issued November 10, 2010.	Audits have not begun, so there are no recoveries yet.
State Medicaid Agency Program Integrity Units	The state Medicaid agency processes Medicaid claims and makes payments, among other things. The program integrity unit of the agency conducts audits of those claims and makes fraud referrals to law enforcement (usually the state attorney general's office).	According to MIG data, there were 54,829 audits conducted in the states resulting in the recovery of $594 million. Overall, states reported $1.3 billion in recoveries from program integrity-related activities.
Medicaid Fraud Control Units (MFCUs)	MFCUs investigate and prosecute suspected provider fraud, often received from referrals from the state Medicaid agencies.	In FY 2009, MFCUs recovered $1.3 billion from both civil and criminal cases.
State Offices of Medicaid Inspector General (OMIGs)	Titles of these offices could vary by state, and only about a dozen states have one. They are often entities created by state statute to coordinate Medicaid program integrity control activities among state agencies. They work closely with MFCUs and other state and federal officials.	Total recoveries not available.

RAC Preparation Checklist

Use this checklist to prepare for recovery audit contract (RAC) audits. It is used with permission from the American Health Information Management Association (AHIMA), Chicago

A. Select RAC team from key departments and identify their role in the RAC process

- ☐ Senior Leadership
- ☐ Finance/revenue cycle
- ☐ Clinical documentation management
- ☐ Health information management (operations, coding and ROI)
- ☐ Case management/care coordination
- ☐ Corporate compliance
- ☐ Business office (operations, Medicare specialist and denials management)
- ☐ Information technology (IT) support services
- ☐ Clinical departments (as needed)
- ☐ Legal (internal and external) medical management

B. Develop departmental policies and procedures

- ☐ Identify primary POC (point of contact) and back-up
- ☐ Know RAC contact numbers
- ☐ Establish in-house contact numbers
- ☐ Create job description for RAC coordinator
- ☐ Maintain tracking system
- ☐ Prepare extension request letter
- ☐ Prepare appeal letters
- ☐ Ensure payment for copies has been received

C. Educate key players through team meetings

- ☐ Know the rules for RAC.
- ☐ Know Medicare policies. (According to the RAC Statement of Work, the RAC shall not help providers with policies.
- ☐ Know difference between automated and complex reviews. Develop proactive approach for education. (Perform a RAC audit before CMS performs a RAC audit.)
- ☐ Educate RAC team.
- ☐ Educate other personnel.

D. Attend provider outreach sessions Prior to entering state, all contractors are required to hold a meeting.

- ☐ Identify times and dates on CMS website (www.cms.hhs.gov/rac) or contractor's internet page. (They should notify you.)

E. Develop tracing and appeals process

- ☐ Identify tracking system, database or file.
- ☐ Know five levels of appeal. (Get to know the RAC contact.)
- ☐ Develop cover letter for each level of appeal (form).
- ☐ Determine who will decide if appeal will be submitted.
- ☐ Determine who should submit the letter.

F. Know time frames

- ☐ **45 days:** records not received within 45 days can be declared an overpayment with no appeal rights for provider
- ☐ **15 days:** discussion period for determination
- ☐ **3-Year:** look-back period from October 1, 2007
- ☐ **August 2009 RAC audit activity begins**
- ☐ **30 Day: write check to avoid interest**
- ☐ **41 Day: Recoupment Period**

G. Identify eligibility for RAC possibilities

- ☐ Inpatient
- ☐ Outpatient
- ☐ Therapy
- ☐ Surgical procedures
- ☐ Incomplete documentation and/or interpretation
- ☐ Evaluation and management (E/M) levels
- ☐ DRG
- ☐ Coding errors
- ☐ Medical necessity
- ☐ Lab, radiology
- ☐ Infusion and transfusion
- ☐ Social worker services in facilities
- ☐ Place of service errors
- ☐ Incident-to-error
- ☐ Stark violations
- ☐ Duplicate billing
- ☐ Debridement coding
- ☐ E/M utilizing modifier 24
- ☐ Pharmaceutical coding in physician offices

H. Know RAC will not review a claim that has been previously reviewed by another HHC contractor including:

- ☐ RACs can correct improper payments when the CMS FI or MAC did not apply the proper edits – NCCI, OCE, MUE, MCE
- ☐ Carrier/FI/MAC medical Review (MR) (prepayment/post-payment claim review program)
- ☐ Comprehensive Error Rate Testing (CERT) Program (post-payment claim review program)
- ☐ Quality Improvement Organization (QIO)
- ☐ Zone Program Integrity Contractor (ZPIC) Former Program Safeguard Contractor
- ☐ Fraud investigations by the Department of Justice (DOJ), Office of Inspector General (OIG) or the state Attorney General (AG)

I. Know RAC contractors

- ☐ Diversified Collection Services – Region A
- ☐ CGI – Region B
- ☐ Connolly Consulting – Region C
- ☐ Health Data Insights – Region D

J. Know RAC subcontractors

- ☐ VIANT – Region C
- ☐ PRG-Schultz – Regions A, B, D