RAC Primer for LTC Facilities

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Last year the Centers for Medicare and Medicaid Services (CMS) began rolling out the Recovery Audit Contractor (RAC) program to all 50 states and all providers, including long-term care facilities. HIM professionals working in LTC facilities need to understand the basics of the program in order to ensure their facilities receive the appropriate payment and successfully manage a RAC audit.

Program Structure

The RAC program divides the country into four regions (A–D), with one contractor assigned to each region. The RACs develop and manage programs for their assigned regions under the direction of CMS.

Under CMS's New Issue Review Board, RACs now have firm controlled procedures outlining their functions and actions. All RAC activities require CMS approval.

RACs look for improper payments using Medicare policies as the foundation of the review. RACs must submit a list of areas that they wish to review to CMS for approval. They cannot review areas previously examined (i.e., fiscal intermediary, Medicare Advantage contractors). Approved review areas are then posted on the RAC's Web site. They may not review cases that are more than three years old.

The RACs can conduct two types of audits: automatic and complex reviews. During the automated review, Medicare payment information from the common working file is transmitted to the RAC computer system. Through the proprietary system generated by each RAC, the computer analyzes data in the file for discrepancies and potential payment errors.

The complex review requires clinical records. The RAC contacts the provider by mail (with a document known as a "demand letter"), outlining the clinical records to be copied and provided to the RAC. The records are then reviewed by clinical staff (e.g., nurses, therapists, and physicians), who are typically subcontracted.

Once the review is complete the RAC notifies the provider of the results and offers the opportunity to discuss any improper payments. This process is not part of the appeal process.

RACs can initiate a new review process and request additional record copies every 45 days. However, providers have different equations for determining the number of RAC record requests per 45 days.

For inpatient hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and hospices, RACs can request records for 10 percent of the average monthly Medicare claims per 45 days. RACs can request 1 percent of average monthly Medicare services per 45 days for other Part A billers such as outpatient hospitals and home health. In either instance, the RAC may request a maximum of 200 records.

Take for example a local community hospital that had 1,200 Medicare paid claims in 2007. The average number of its claims per month is 100 (1,200 claims divided by 12 months). Ten percent of that monthly average amount would be 10. Therefore the RAC medical requests would be limited to 10 medical records per 45 days.

The provider has 45 days to submit the copies of the requested record or to submit a request for an extension.

Identified Areas of Focus

Each RAC is required to establish a Web site to post the issues of focus, audit results, and educational and contact information. This information should be used to determine if a facility is in compliance prior to an audit.

RAC Focus Areas

Issues	RAC	Claim Types	States
Pharmacy Supply and Dispensing Fees	RAC A	DME Suppliers	District of Columbia, Connecticut, Massachusetts, Maryland, Maine, Delaware, New Jersey, New York, New Hampshire, Pennsylvania, Rhode Island, Vermont
Wheelchair Bundling	RAC A	DME Suppliers	District of Columbia, Connecticut, Massachutts, Maryland, Maine, Delaware, New Jersey, New York, New Hampshire, Pennsylvania, Rhode Island, Vermont
Urological Bundling	RAC A	DME Suppliers	District of Columbia, Connecticut, Massachusetts, Maryland, Maine, Delaware, New Jersey, New York, New Hampshire, Pennsylvania, Rhode Island, Vermont
Blood Transfusions	RAC B	Outpatient Hospital, Physician	Indiana, Michigan, Minnesota
IV-Hydration	RAC B	Outpatient Hospital, Physician	Indiana, Michigan, Minnesota
Bronchoscopy Services	RAC B	Outpatient Hospital, Physician	Indiana, Michigan, Minnesota
Wheelchair Bundling	RAC C	DME	Alabama, Alaska, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
Urological Bundling	RAC C	DME	Alabama, Alaska, Colorado, Florida, Georgia, Lousiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
Clinical Social Worker Services	RAC C	CSW Providers	Florida
Blood Transfusions	RAC C	Outpatients Hospitals, Physician	Alabama, Florida, Georgia, South Carolina
Untimed Codes	RAC C	Outpatients Hospitals, Physician	Alabama, Florida, Georgia, North Carolina, South Carolina
IV Hydration Therapy	RAC C	Outpatients Hospitals, Physician	Alabama, Florida, Georgia, South Carolina
Bronchoscopy Services	RAC C	Outpatients Hospitals, Physician	Alabama, Georgia, South Carolina
Once in a Lifetime procedures	RAC C	Outpatients Hospitals, Physician	Florida, Georgia, North Carolina, South Carolina
Pediatric codes exceeding age parameters	RAC C	Outpatients Hospitals, Physician	Alabama, Florida, North Carolina, South Carolina

J2505; Injection, Pegfilgrastin, 6mg	RAC C	Outpatients Hospitals, Physician	Florida, Georgia, North Carolina, South Carolina
Newborn Pediatric CPT Codes Billed for Pts Exceeding Age Limit	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Once in a Lifetime (procedures performed only once in a lifetime)	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Excessive Units – Untimed Codes	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Excessive Units – Blood Transfusion	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Excessive Units – Bronchoscopy	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Excessive Units – IV Hydration	RAC D	Part A OP, part B	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas
Neulasta	RAC D	Part A OP	Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, Northern Marianas

For more information on each of the identified issues, go to the specific RAC's Web site, listed in the table "Recovery Audit Contractors" below.

Issues specific to skilled nursing facilities that were identified in the earlier RAC demonstration project included:

- Use of acute care diagnoses without services provided that are in relationship to the type of care and services the diagnosis may warrant
- A higher resource utilization group score
- The acceptance of the procedural codes from the hospital record
- Therapies not medically supported by the diagnosis

Correctly assigned V codes can be used per the "ICD-9-CM Official Guidelines for Coding and Reporting."

Recovery Audit Contractors

RAC	Web Site	E-mail	Telephone Number	Subcontractors
Region A: Diversified Collection Services	URL	info@dcsrac.com	(866) 201-0580	PRG Shultz, iHealth Technologies, and Strategic Health Solutions
Region B: CGI Technologies and Solutions	URL	racb@cgi.com	(877) 316-7222	PRG Schultz
Region C: Connolly Consulting Associates	URL	RACinfo@connollyhealthcare.com	(866) 360-2507	Viant, Inc.
Region D: HealthDataInsights	URL	racinfo@emailhdi.com	Part A: (866) 590-5598 Part B: (866) 376-2319	PRG Schultz

Appeal Process

There are five levels to an appeal.

Level 1, redetermination, is carried out by the fiscal intermediary (FI) or the Medicare Advantage carrier (MAC). The appeal must be submitted via form CMS-20027 no later than 120 days from the date of the RAC's initial determination of overpayment. Additional clinical record information can be provided during this appeal level. The review must be completed within 60 days of the notification.

Level 2, reconsideration, is carried out by the qualified independent contractor (QIC). The request is sent via form CMS-20033 directly to the QIC, not the FI or the MAC. The appeal must be submitted within 180 days of the date of the redetermination (level one) decisions. Additional clinical record information can be provided during reconsideration. The review must be complete within 60 days of the date of the redetermination.

Level 3 is the administrative law judge. This appeal is filed with the entity specified in the QIC reconsideration notice. It must be filed within 60 days of the date of the QIC's reconsideration notice. The review must be completed within 90 days.

Level 4 involves the Medicare Appeals Council. It is carried out by an independent agency within the Department of Health and Human Services. The appeal must be submitted within 60 days of the decision by an administrative law judge. The agency has 90 days to complete the review.

Finally, level 5 is a federal court review using the federal court system. An appeal at this level must be filed within 60 days of the decision by the Medicare Appeals Council.

The facility administration and clinical records staff should know the RAC appeal process because additional information from the clinical record can be submitted during the first two levels of the appeal. Once the appeal has reached the level of the administrative law judge and higher, no additional clinical record information can be submitted. Therefore, it is important to review the record and make sure that all the necessary information is submitted.

Providers have a number of options once a notice of payment adjustment is received from the RAC. Providers may pay the recoupment within 30 days, contact the RAC to request a payment plan, allow Medicare to recoup the funds from future payments, or file an appeal. If the facility chooses to file an appeal but does not pay the recoupment prior to the resolution of the appeal, it may be subject to an interest assessment, identified as 11 percent, on the amount of the recoupment.

Provider Activities

Organizations should proactively address the RAC process to ensure a positive outcome. In order to facilitate a positive outcome, organizations should:

- Identify a specific position to be the point person for contacts with the RAC
- Provide the contact information for the point person on the RAC Web site
- Determine the preferred mode of medical record submission (e.g., hard copy, CD, or DVD)
- Educate staff on the importance of timely communication and follow-up regarding the receipt of a notice or request for records
- Consider increasing staff levels or hours to address additional record requests
- Establish a method to track the RAC requests, the facility's response, and the appeal process if initiated
- Develop procedures to manage the process
- Identify trends in the facility's denial history
- Develop documentation guidelines
- Develop an audit process to ensure documentation is appropriate
- Educate staff on correct documentation practices
- Develop a decision tree for the appeal determination
- Obtain current ICD-9-CM coding tools and manuals
- Train staff in correct ICD-9-CM coding procedures
- Monitor the Office of the Inspector General reports for improper payment information
- Monitor the RAC Web sites for information regarding audit topics and results
- Perform an internal assessment of the Medicare documentation process
- Identify corrective actions and monitor their implementation

Resources

AHIMA. "Recovery Audit Contractor (RAC) Toolkit."

Centers for Medicare and Medicaid Services. "Recovery Audit Contractor." Available online at www.cms.hhs.gov/RAC.

National Center for Health Statistics. "ICD-9-CM Official Coding Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/data/icd9/icdguide09.pdf.

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