The Recovery Audit Program and Medicare

The Who, What, When, Where, How and Why?

Agenda

- What Is A Recovery Auditor?
- Will The Recovery Auditors Affect Me?
- Why Recovery Auditors?
- What Does A Recovery Auditor Do?
- What Are The Providers' Options?
- What Can Providers Do To Get Ready?

What Is A Recovery Auditor?

The Recovery Auditors Program Mission

- The Recovery Auditor detect and correct past improper payments so that CMS can implement actions that will prevent future improper payments:
  - **Providers** can avoid submitting claims that do not comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** and future Medicare beneficiaries are protected.

Will The Recovery Auditors Affect Me?

- Yes, if you bill fee-for-service programs, your claims will be subject to review by the Recovery Auditors.

Why Recovery Auditors?

Recovery Audit Legislation:

- Medicare Modernization Act, Section 306

  Required the three year Recovery Audit demonstration

- Tax Relief and Healthcare Act of 2006, Section 302

  Requires a permanent and nationwide Recovery Audit program by no later than 2010

  Both Statutes gave the CMS the authority to pay the Recovery Audits on a contingency fee basis.

What Does A Recovery Auditor Do?

The Recovery Audit Review Process:

- Recovery Auditors review claims on a post-payment basis
- Recovery Auditors use the same Medicare policies as Carriers, FIs and MACs: NCDs, LCDs and the CMS Manuals
- Three types of review:
  - Automated (no medical record needed)
  - Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
  - Complex (medical record required)
- Recovery Audits look back three years from the date the claim was paid
- Recovery Auditors are required to employ a staff consisting of nurses, therapists, certified coders and a physician CMD

The Collection Process

- Same as for Carrier, FI and MAC identified overpayments
  - Carriers, FIs and MACs issue Remittance Advice
    - Remark Code N432: Adjustment Based on Recovery Audit
  - Carrier/FI/MAC recoups by offset unless provider has submitted a check or a valid appeal.

What Is Different?

- Recovery Auditors will offer an opportunity for the provider to discuss the improper payment determination with the Recovery Auditors (this is outside the normal appeal process)
- Issues reviewed by the Recovery Auditor will be approved by the CMS prior to widespread review
- Approved issues will be posted to a Recovery Audits Website before widespread review

What Are The Providers' Options?

If you agree with the Recovery Auditor determination:

- Pay by check
- Allow recoupment from future payments
- Request or apply for extended payment plan
- Appeal

Appeal Timeframes

http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf

935 MLN Matters

http://www.cms.hhs.gov/MLNMatterArticles/downloads/MM6183.pdf

Three Keys to Success

- Minimize Provider Burden
- Ensure Accuracy
- Maximize Transparency

Minimize Provider Burden

- Limit the Recovery Auditors “look back period” to three years
- Recovery Auditors will accept imaged medical records on CD/DVD
- Limit the number of medical record requests—ADR Limits: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Provider-Resource.html

Ensure Accuracy

- Each Recovery Audit team employs:
  - Certified coders
  - Nurses
  - Therapists
  - A physician CMD
- The CMS' New Issue Review Board provides greater
- oversight
- Recovery Audit Validation Contractor provides annual accuracy scores for each Recovery Audit organization
- If a Recovery Auditor loses at any level of appeal, the Recovery Auditor must return its contingency fee

Maximize Transparency

- New issues are posted to the Web
- Vulnerabilities are posted to the Web
- Recovery Audit claim status Website
- Detailed Review Results Letter following all Complex Reviews

What Can Providers Do?

1. **Know Where Previous Improper Payments Have Been Found:**
   - Look to see what improper payments were found by the Recovery Auditors:
     - Demonstration findings: www.cms.hhs.gov/rac
   - Look to see what improper payments have been found in OIG and CERT reports:
     - OIG reports: www.oig.hhs.gov/reports.html
     - CERT reports: www.cms.hhs.gov/cert

What Can Providers Do?

2. Know If You Are Submitting Claims With Improper Payments:

- Conduct an internal assessment to identify if you are in compliance with Medicare rules
- Identify corrective actions to promote compliance
- Appeal when necessary
- Learn from past experiences

Prepare To Respond To Recovery Auditors Medical Record Requests

- Tell your Recovery Auditor the precise address and contact person they should use when sending Medical Record Request Letters:
  - Call Recovery Auditor
  - Use Recovery Audit Programs' Websites
- When necessary, check on the status of your medical record (Did the Recovery Auditor receive it?):
  - Call Recovery Auditor
  - use Recovery Audit Programs' Websites

Appeal When Necessary

- The appeal process for Recovery Audit denials is the same as the appeal process for Carrier/FI/MAC denials
- Do not confuse the “Recovery Audit Programs’ Discussion Period” with the Appeals process
- If you disagree with the Recovery Auditor’s determination:
  - Do not stop with sending a discussion letter
  - File an appeal before the 120th day after the Demand letter.

Learn From Past Experiences

- Keep track of denied claims
- Look for patterns
- Determine what corrective actions you need to take to avoid improper payments.

Contact Information

- Recovery Audit Programs' Website: www.cms.hhs.gov/RAC
- Recovery Audit Programs' E-mail: RAC@cms.hhs.gov