AMERICAN ACADEMY OF DERMATOLOGY

RAC AUDIT SURVIVAL TOOLKIT

Authors:

Faith C. M. McNicholas, CPC, CPCD, PCS, CDC
Manager, Coding and Reimbursement

Peggy Eiden, CPC, CCS-P
Coding and Reimbursement Specialist

Mariana Abarca, CPC, CPCD
Coding and Reimbursement Specialist

Rachna Chaudhari, MPH
Manager, Practice Management

Cindy Bracy, RHIA, CCS-P,
Senior Specialist, Practice Management

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Audits have become increasingly prevalent within the medical practice environment, and dermatologists must be prepared before they find themselves facing a Centers for Medicare & Medicaid Services (CMS) Recovery Contractor Audit (RAC). This toolkit provides a foundation for dermatologists and their office staff to become knowledgeable about RAC audits and what to do in the event of facing one.

Please note that if your office is contacted about an audit, you should always contact your attorney and/or the Academy at (866) 503-7546 or email ppm1@aad.org.

Recovery Audit Contractor (RAC) audit process

Developed by the Centers for Medicare and Medicaid Services (CMS) in 2005, the Recovery Audit Contractor (RAC) program is the product of a successful audit program used as a cost-effective means to ensure that correct payments are being made to providers and suppliers that participate in the Medicare Fee-for-Service Program. The mission of the RAC is to provide CMS with a means to identify improper payments, as well as a tool to prevent future overpayments and/or underpayments made to providers who participate in the Medicare Fee-for-Service Program.

Who is eligible to be audited?

RACs are authorized to investigate claims that all physicians, providers facilities and suppliers submit. Everyone who provides Medicare beneficiaries in the Fee-for-Service program with procedures, services, and treatments and submits claims to Medicare is eligible to be audited.

Basis for the audit

RACs have been assigned a specific region of the country and they will receive a claims file from CMS. The file contains the past claims data from the National Claims History (NCH), compiling the claims that have been processed and paid after Oct. 1, 2007 in that assigned region. Monthly updates, including the current fiscal year, will be sent thereafter. RACs employ their own custom-designed computer programs and processes, using their uniquely developed criteria based on Medicare rules and regulations, accepted clinical standards of medical practice, and coding and billing policies to determine which specific sectors to review. They also may reference specific services included in the current year of the Office of the Inspector General's (OIG) work plan, as well as Government Accountability Office (GAO) and Comprehensive Error Rate Testing (CERT) findings. From this information, the RAC will identify those situations in which claims have a high probability to be overpaid (and underpaid) in their region. These are then entered into the RAC database for each claim to identify providers and begin the analysis and recoupment process.

Types of audits

There are two types of audits: automated reviews and complex reviews. An automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record, such as data mining. Errors found must be clearly non-covered services or incorrect application of coding rules and conventions and must be supported by Medicare policy, approved article or coding guidance.

A complex review occurs when a RAC makes a claim determination using human review of the medical record. Records requiring a complex review are those with high probability of non-covered service or when there is no definitive Medicare policy, Medicare article or Medicare-sanctioned coding guideline. RAC audits can review all aspects of the supporting medical records, including evaluation and management (E/M) services.

The overpayment collection process

When Medicare discovers an overpayment of $10 or more, the overpayment recovery process will be initiated. Here’s how the review process works:

The RAC:
- Requests medical records from the provider;
• Reviews the medical records submitted; and
• Determines and communicates its findings with the provider and Medicare Administrative Contractor (MAC) who, in turn, adjusts the reimbursement, documenting it through a remittance advice.

1. Demand letters
   ✓ The first demand letter is sent requesting payment. This letter explains to the provider that interest will accrue from the date of the demand letter if the overpayment is not received by the 31st calendar day from the date listed on the letter.

   ✓ If no response is received from the physician or supplier within 30 calendar days after the date of the first demand letter, a second demand letter will be sent.

   ✓ If a full payment is not received within 40 calendar days from the date on the first demand letter, recoupment procedures will begin on the 41st day. Recoupment means that the overpayment will be recovered from current payments due or from future claims submitted. If a debt has not been paid or recouped (unless a valid appeal has been filed), a third demand letter will be sent within 120 days indicating that the overpayment may be eligible for referral to the Department of Treasury for offset or collection.

2. Appealing Medicare decisions
   Once an initial claim determination is made to providers, participating physicians, etc., have the right to appeal that decision if they feel it is unfavorable. However, dermatologists who do not take assignment on claims have limited appeal rights. All appeal requests must be made in writing.

   • Rebuttal
     A physician or supplier may submit a rebuttal statement to the contractor within 15 calendar days from the date of a demand letter. The rebuttal statement explains or provides evidence regarding why recoupment should not be initiated. The rebuttal process is not considered an appeal and does not cease contractor recoupment activities.

Tips for filing an appeal letter

♦ Make sure you submit all of your documentation ON TIME.

♦ Make a packet of materials, including medical records, referral letters, patient history, clinical decision-making, etc.

♦ Date and page stamp all of your materials.

♦ Include a title page in this packet of materials that contains an organized breakdown of what is contained in the packet. State exactly what page the specific condition is listed on in the medical record.

♦ Include journal articles and clinical standards supporting your medical decision-making.

♦ Don’t assume the QIC panel reviewing your case is made up of clinical experts. Many of them may not have thorough clinical backgrounds.

♦ Have someone with no knowledge of the case review the file before it is sent out for obvious errors or missing materials.

♦ Research other local coverage determinations (LCDs) to document if they support your case.

Note: You can send additional materials to the QIC after you have submitted your appeals letter as long as it is sent BEFORE QIC begins reviewing your case.
Levels of the appeals process

Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- **Request for redetermination by a Medicare Administrative Contractor (MAC): First level of appeal**

  If a physician or supplier disagrees with an overpayment decision, he or she may file an appeal (an examination of a claim by MAC personnel who are different from the personnel who made the initial determination) with the contractor (MAC) that issued the original decision. A redetermination is the first level of appeal in which a qualified employee of the contractor conducts an independent review of the decision.

  A redetermination request must be filed within 120 calendar days from the date of the demand letter. To stop the initial recoupment process, the redetermination request must be filed within 30 calendar days from the date of the demand letter. If the redetermination request is filed later than 30 calendar days from the date of the demand letter, the recoupment process will stop when the appeal is filed; however, any recoupment already taken will not be refunded.

  A request for a redetermination may be filed on Form CMS-20027, available at [http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage](http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage). A written request not made on Form CMS-20027 must include:

  ✓ Beneficiary name
  ✓ Medicare Health Insurance Claim (HIC) number
  ✓ Specific service and/or item(s) for which a redetermination is being requested
  ✓ Specific date(s) of service
  ✓ Name and signature of the party or the representative of the party

  The dermatologist must attach any supporting documentation to the redetermination request. MACs will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

  **NOTE:** Contractors can no longer correct minor errors and omissions on claims through the appeals process.


  *There is no minimum monetary threshold required to request a redetermination.*

- **Reconsideration by a Qualified Independent Contractor (QIC) Review: Second Level of Appeal**

  Following an unfavorable or partially favorable redetermination decision, the dermatologist may request a second level of appeal or reconsideration by a Qualified Independent Contractor (QIC). A request for reconsideration by a QIC must be filed within 180 calendar days of the date the redetermination decision is received. To stop the recoupment process from starting, a reconsideration request must be filed within 60 days from the redetermination decision date.
To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN) and complete a Form CMS-20033, which can be found by going to the CMS website at [http://www.cms.gov/cmsforms/downloads/CMS20027.pdf](http://www.cms.gov/cmsforms/downloads/CMS20027.pdf). This form will be mailed with the Medicare Remittance Notice (MRN/EOB/ERA). If for some reason the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the author or appointed representative of the party
- Name of the contractor that made the redetermination

The request should then **clearly explain why you disagree with the redetermination**. A copy of the MRN and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. If you have any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision.

_Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late._

The recoupment process will stop when the reconsideration by a QIC request is received and validated. After the QIC’s decision or dismissal, the recoupment process will resume for any overpayment amount that has not been paid in full regardless of whether the physician or supplier requests further appeal levels.

**Notification of reconsideration decision**

Reconsiderations are conducted on the record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information about further appeal rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an administrative law judge.

**Hearing by an administrative law judge: Third level of appeal**

If the second level of appeal is unfavorable and there still is a minimum of $130 remaining in controversy following the QIC’s decision, the dermatologist may request an administrative law judge (ALJ) hearing within 60 days of receipt of the reconsideration. Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing. The appellant must also send notice of reconsideration and verify this on the hearing request form or in the written request. ALJ hearings are generally held by video-teleconference (VTC) or by telephone. You may ask for an in-person hearing if you do not want a VTC or telephone hearing. The dermatologist must demonstrate good cause for requesting an in-person hearing and the ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Dermatologists also may ask the ALJ to make a decision without a hearing (on the record). Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing. The ALJ will generally issue a decision within 90 days of receipt of the hearing request.
This timeframe may be extended for a variety of reasons including, but not limited to:

- case escalation from the reconsideration level;
- submission of additional evidence not included with the hearing request;
- request for an in-person hearing;
- dermatologist’s failure to send notice of the hearing request to other parties; and
- initiation of discovery if CMS is a party.

If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level.

**NOTE:** The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. **The amount in controversy threshold for 2011 is currently $130.**

- **Review by the Medicare Appeals Council within the Departmental Appeals Board (AKA the Appeals Council): Fourth level of appeal**

  If a party to the ALJ hearing is dissatisfied with the ALJ’s decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. **The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ’s decision,** and must specify the issues and findings that are being contested. Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review. In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons including, but not limited to, the case being escalated from an ALJ hearing.

  If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Appeals Council to escalate the case to the Judicial Review level.

- **Judicial Review in U.S. District Court: Fifth Level of Appeal**

  If the fourth level of appeal is unfavorable and there still is a minimum of at least $1,260 or more in controversy following the Appeals Council’s decision, a dermatologist may request judicial review before a U.S. District Court judge.

  The dermatologist must **file the request for review within 60 days of receipt of the Appeals Council’s decision.** The Appeals Council’s decision will contain information about the procedures for requesting judicial review.

  **NOTE:** The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2011 is $1,300.

3. **Repayment plans**

   If the physician or supplier is unable to pay the entire amount requested for the overpayment in full, he or she may contact the contractor to request an extended repayment plan.
Frequently asked questions (FAQs)

**Whose claims will be reviewed under the RAC program?**
All physicians, non-physician providers and suppliers who submit claims to Medicare fee-for-service program are subject to RAC reviews. Response to a RAC medical record request must be made within 45 calendar days. Providers may seek an extension from the RAC at any time prior to the 45th day.

**RAC Medical Record Requests: Physicians (by NPI)**

- Solo practitioner  
  Limit = 10 medical records/45 days
- Partnership of two to five individuals  
  Limit = 20 medical records/45 days
- Group of six to fifteen individuals  
  Limit = 30 medical records/45 days
- Large group (sixteen or more)  
  Limit = 50 medical records/45 days

RACs are required to reimburse providers for photocopying medical records at a rate of 12 cents per page. Practices are not required to submit vouchers/statements to the RAC requesting payment. RACs will automatically issue payments to the practice for photocopying charges within 45 days of receiving the medical record.

**Should providers notify the RAC when they perform self-audits?**
Yes. If a provider does a self-audit and identifies improper payments, the provider should report the improper payments to the appropriate Medicare claims processing contractor. The exact information necessary for the self-referral can be determined by contacting your local carrier, or MAC. There are two types of self-audits. One is called a voluntary refund and is claim-based. If the required claim
information is included along with the amount of the improper payment, the claim will be adjusted by the claim processing contractor. The RAC will be aware of the adjustment, but the refund does not preclude future reviews.

The second type of self-audit may involve the use of extrapolation. If extrapolation is used, the claim-processing contractor will review the case file to determine if it is acceptable. The claim-processing contractor will accept or deny the extrapolation for the issue identified by the provider. If the claim-processing contractor accepts the extrapolation, those claims in that realm will be excluded from RAC review.

If a provider repays or Medicare recoups an alleged overpayment identified by the RAC and the provider later wins an appeal, CMS will at certain times reimburse the provider with interest. The payment of interest in response to a favorable provider appeal decision is determined by CMS's interpretations of the appeal regulations. These regulations determine the process for all overpayments, not just RAC-identified overpayments.

**Will the RAC appeal process mirror the regular Medicare appeal process?**
If this is any consolation, the Medicare Appeals process will remain the same and RACs will not review a claim that has previously been reviewed by another entity.

**If a RAC requests documentation from me, how long do I have to respond?**
You have 45 calendar days from the day of the request to respond. You also may ask for an extension.

**Can I appeal RAC findings?**
Yes. Appeals may be sent in writing to the RAC contractor within 15 days of receiving the RAC letter identifying overpayment. The appeal letter should refer to Medicare policy, statute or medical record documentation that refutes the reason for denial. The appeal process is exactly the same as the regular Medicare appeals process which is detailed on the next page.

**Who can I contact for specific RAC questions?**
CMS has set up an email address for all providers to send questions regarding RACs, which is RAC@cms.hhs.gov. See the table below for more information.
<table>
<thead>
<tr>
<th>RAC</th>
<th>Website</th>
<th>Email</th>
<th>Telephone number</th>
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<tbody>
<tr>
<td><strong>Region A: Diversified Collection Services</strong>&lt;br&gt;States Include: Vermont, Maine, Massachusetts, New York, Pennsylvania, New Hampshire, New Jersey, Connecticut, Rhode Island, Delaware and Maryland</td>
<td><a href="http://www.dcsrac.com">www.dcsrac.com</a></td>
<td><a href="mailto:info@dcsrac.com">info@dcsrac.com</a></td>
<td>(866) 201-0580</td>
</tr>
<tr>
<td><strong>Region B: CGI</strong>&lt;br&gt;States Include: Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio and Kentucky</td>
<td><a href="http://www.racb.cgi.com">www.racb.cgi.com</a></td>
<td>racb.cgi.com</td>
<td>(877) 316-7222</td>
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<tr>
<td><strong>Region C: Connolly Inc.</strong>&lt;br&gt;States Include: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Tennessee, Mississippi, Georgia, Alabama, Florida, South Carolina, North Carolina, Virginia and West Virginia</td>
<td><a href="http://www.connollyhealthcare.com/RAC">www.connollyhealthcare.com/RAC</a></td>
<td><a href="mailto:RACinfo@connollyhealthcare.com">RACinfo@connollyhealthcare.com</a></td>
<td>(866) 360-2507</td>
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<tr>
<td><strong>Region D: HealthDataInsights</strong>&lt;br&gt;States Include: Iowa, Missouri, Kansas, Nebraska, South Dakota, North Dakota, Wyoming, Montana, Idaho, Utah, Nevada, Arizona, California, Washington, Oregon, Alaska and Hawaii</td>
<td><a href="http://www.racinfo.healthdatainsights.com">www.racinfo.healthdatainsights.com</a></td>
<td><a href="mailto:racinfo@emailhdi.com">racinfo@emailhdi.com</a></td>
<td>Part A: (866) 590-5598 Part B: (866) 376-2319</td>
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**CMS Regional Offices: Region I-X**
The Regional Office should be your initial point of contact on any Medicare, Medicaid or State Children’s Health Insurance Program (SCHIP) issues.

<table>
<thead>
<tr>
<th>CMS: Region I (CT, ME, MA, NH, RI, VT)</th>
<th>CMS: Region II (NJ, NY, PR, USVI)</th>
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<tbody>
<tr>
<td>Carol Maloof, Acting and Deputy Regional Administrator</td>
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<tr>
<td>Office of the Regional Administrator</td>
<td></td>
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<tr>
<td>JFK Federal Building</td>
<td></td>
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<tr>
<td>Room 2325</td>
<td></td>
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<tr>
<td>Boston, MA 02203-0003</td>
<td></td>
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<tr>
<td>Phone: (617) 565-1188</td>
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<tr>
<td>Fax: (617) 565-1339</td>
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</tr>
<tr>
<td>Email: <a href="mailto:robosora@cms.hhs.gov">robosora@cms.hhs.gov</a></td>
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<tr>
<th>CMS: Region III (DE, DC, MD, PA, VA, WV)</th>
<th>CMS: Region IV (AL, NC, SC, FL, GA, KY, MS, TN)</th>
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<tbody>
<tr>
<td>Nancy B. O’Connor, Regional Administrator</td>
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<tr>
<td>Office of the Regional Administrator</td>
<td></td>
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<tr>
<td>The Public Ledger Building</td>
<td></td>
</tr>
<tr>
<td>Suite 216</td>
<td></td>
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<tr>
<td>150 S Independence Mall West</td>
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<tr>
<td>Philadelphia, PA 19106</td>
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<tr>
<td>Phone: (215) 861-4140</td>
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<tr>
<td>Fax: (215) 861-4140</td>
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<tr>
<td>Email: <a href="mailto:rophiora@cms.hhs.gov">rophiora@cms.hhs.gov</a></td>
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<tr>
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<th>CMS: Region VI (AR, LA, NM, OK, TX)</th>
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<tbody>
<tr>
<td>John Hammarlund, Regional Administrator</td>
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<tr>
<td>Office of the Regional Administrator</td>
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<tr>
<td>233 North Michigan Avenue</td>
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<tr>
<td>Suite 600</td>
<td></td>
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<tr>
<td>Chicago, IL 60601</td>
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<tr>
<td>Phone: (206) 615-2306/(312) 353-3653</td>
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<tr>
<td>Fax: (312) 353-0252</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:rosea_ora2@cms.hhs.gov">rosea_ora2@cms.hhs.gov</a></td>
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<tr>
<th>CMS: Region VII (IA, KS, MO, NE)</th>
<th>CMS: Region VIII (CO, MT, ND, SD, UT, WY)</th>
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<tr>
<td>Diane Livesay: Acting Regional Administrator</td>
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<td>Office of the Regional Administrator</td>
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Additional Resources about Audits

American Academy of Family Physicians (AAFP) Auditing Tool:
http://www.aafp.org/fpm/20000400/28usin.html#boxd

American Medical Association (AMA):

American Academy of Professional Coders (AAPC):

Centers for Medicare & Medicaid Services (CMS):
Medicare Recovery Audit Contractors: http://www.cms.hhs.gov/RAC/
Medicaid Program Integrity: http://www.cms.hhs.gov/MedicaidIntegrityProgram/
Comprehensive Error Rate Testing (CERT) Program: http://www.cms.hhs.gov/CERT/

Office of Audit Services (OAS):
http://oig.hhs.gov/oas/

Office of Inspector General (OIG):
http://oig.hhs.gov/

Physician’s Practice Articles:
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1133.htm
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/183.htm
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/844.htm
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/420.htm
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/423.htm