Recovery Audit Contractor (RAC) Programs

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The Affordable Care Act (ACA) requires each state Medicaid program to establish a Recovery Audit Contractor (RAC) program to identify overpayments and underpayments by Medicaid programs to physicians, hospitals, and other providers. Many pediatricians have already received RAC demand letters, giving them 30 days to refund alleged overpayments -- often in the tens of thousands of dollars -- or appeal the recoupments.

If your practice receives such a letter, the following strategy may be helpful for evaluating the appropriateness of the recoupment request.

1) **Know the parameters of your state’s RAC program.** CMS has given states enormous latitude in structuring their RAC programs, in selecting a contractor, establishing an appeals process, setting the look back period, and choosing scope of claims (e.g. whether to include managed Medicaid plans). Here are some resources for familiarizing yourself with the rules of your state’s RAC program:
   a. CMS’ general instructions to state Medicaid offices on Medicaid RAC programs: [http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/Medicaid_RAC_FAQ.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/Medicaid_RAC_FAQ.pdf)
   b. A clickable map of Medicaid RAC program information state-by-state, including implementation date, contractor(s), and RAC medical director: [http://w2.dehpg.net/RACSS/Map.aspx](http://w2.dehpg.net/RACSS/Map.aspx)

2) **Understand that RACs are usually paid on a contingency fee for what they recover for the state.** There is no penalty to RACs for over-reporting recoupments which are overturned on appeal. Thus, RACs will respond to the incentive of their fee structure by casting a very broad net. Even if a mere third of the RAC’s letters result in successful payments, collecting their cut of 10-20% results in significant fees for the company.

3) **Understand that RACs are also supposed to identify underpayments, not just overpayments.** CMS published a report on the results of its 2011 Medicare RAC programs (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf). Approximately 15% of erroneous payments identified were underpayments, and $141 million was restored to providers.
4) **Know the frequency with which inappropriate or erroneous RAC recoupment requests occur.** In the 2011 Medicare RAC report, only 6% of claims were appealed by providers at any level— but, of appealed claims, 44% were decided in the provider’s favor. “Decisions in the provider’s favor” includes any outcome that did not involve repayment of money by the physician. These include both incorrectly-coded claims that were made compliant as part of the appeal (e.g. addition of a modifier or correcting the number of units), as well as claims that were correctly coded to begin with.

5) **Know how RAC programs determine what claims have been “overpaid.”** In general, compliance programs use two methods to identify potential overpayments.

   a. The first method (“automated”) uses claims data alone to find potential payment errors. For example, a pediatrician sees a teen as cross-cover for a colleague, then again two years later for a sports physical. The pediatrician inaccurately codes the sports physical as a new patient visit. Medical records are not needed to determine that the physician had provided professional services to the patient in the previous 3 years; the RAC can see that the physician’s NPI was billed to that patient’s insurance ID number simply from the claims history.

   b. The second method (“complex”) requires medical records to properly determine whether an overpayment has occurred. A physician who codes 60% of established patient visits as 99214 or 99215 would be considered a coding outlier, but an auditor could not determine what percent of claims (if any) were upcoded without doing a comprehensive medical record review.

Automated overpayment identification is particularly popular because it requires less time and overhead by the RAC. While the complex method requires laborious medical record review by certified coders familiar with a physician’s specialty, the automated method needs only relatively simple spreadsheet software to analyze claims data supplied by the Medicaid program.

Complex overpayment identification may legitimately use extrapolation to determine overpayments. That is, let’s say 15% of a physician’s E&M codes are 99215s. The RAC, suspecting over-coding, requests a random sample of 50 charts within a 3-year period and reviews the coding level. The RAC coder believes that 34 of the 50 charts were upcoded and should properly be 99214s. The RAC may then legitimately expect repayment for the difference between a 99214 and 99215 for not only these 34 claims, but also for 68% (34/50) of all 99215s in the period under review. As long as the RAC can demonstrate that the 50 charts reviewed constituted a statistically-valid sampling, this extrapolation is acceptable to CMS.

6) **Learn what kinds of pediatric claims are often inappropriately targeted by RAC programs.**

Certain CPT code combinations tend to appear in automated overpayment demand letters. In many cases, the code combination was completely legitimate at the time the claim was paid, but at the time the RAC recovery was run – up to 5 years later in some cases – a modifier should have been added.

For example, one RAC program identified E&M visit codes paired with respiratory services codes (like nebulizer treatments or spirometries) as potential overpayments. The auditor took the position that, for example, in 2009, an E&M code 99214 should have been modified with -25 (separately identifiable E&M service) if a nebulizer treatment 94664 was also performed that same day. At the time the service was performed, that state’s Medicaid program did not require a -25 modifier for this code combination, and even in 2013 the modifier requirement was inconsistent between that state’s Medicaid MCOs.

Similarly, on January 1, 2013, CMS began to require that modifier -25 be added to preventive E&M codes when vaccines (CPTs 9046x, 9047x) were also administered ([http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Announcement.aspx](http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Announcement.aspx)). RAC programs have started to apply the 2013 rule to claims under review from 2012 and earlier.

Retroactive application of a current rule to a claim that predates the coding rule – an *ex post facto* demand – is inappropriate and can successfully be appealed.

Other demand letters result from a misunderstanding – or ignorance – of the peculiarities of pediatric practice. One RAC program sent demand letters for improper use of new patient E&M codes. As per CMS guidelines, a new patient is one who has not received any professional services from the physician’s specialty in the physician’s group for the past 3 years. Some recoupment requests properly identify incorrect use of a new patient E&M code, when the patient had been seen by that physician recently.

However, many apparent RAC “overpayments” relate to newborn claims billed under the mother. For example, let’s say 19 year old Jane is seen by Dr. Miller on 5/5/09 for nausea and weakness. Dr. Miller does a urine pregnancy test, which is positive; Dr. Miller refers Jane to an OB for ongoing care. When Jane’s son is born, he returns to Dr. Miller for a newborn visit on 1/13/10. Dr. Miller bills the newborn visit using Jane’s Medicaid ID number, pursuant to Medicaid billing guidelines in Dr. Miller’s state.

However, a RAC program that reviews only Medicaid ID numbers and billing provider NPIs – without looking at the “guarantor relationship to patient” or “patient date of birth” fields – will see a new patient visit on 1/13/10, which is less than three years after 5/5/09. This will be flagged as an “inappropriate” new patient E&M code. Similarly, Jane’s second baby, born on 3/1/12, may also be appropriately coded as a new patient – but identified by the RAC as a second overpayment to the pediatrician. Twin births (two new patient codes billed under mother’s Medicaid ID) also have been identified as being “duplicate payments” and subject to recovery, simply because the RAC program did not have a process to check for multiple births.
7) **Review your RAC demand letter(s) carefully.** Do not be afraid to ask questions. While some RAC demand letters contain a clear list of affected claims, the coding pattern(s) under review, justification for the recoupments, and a clear appeal process, other letters include very limited information or vague, self-referential explanation. You may find it necessary to send a “0th level appeal” (is this a standard name for an initial request for clarifying information?) in which you list all the information you’ll need from the RAC before you can even determine to which claims they’re referring.

8) **Make all your responses to the RAC program – submission of records, rebuttals, appeals, and so on – in writing to the address listed on the letter with return receipt requested.** The importance of a paper trail cannot be overstated. Although a phone number is often listed on the letterhead, most state RAC appeals processes require all materials to be submitted in writing, or providers lose their appeal rights.

9) **If RAC demand letters have a high proportion of inappropriate recoupment requests, consider reporting this to your state Medicaid bureau.** State Medicaid agencies have a fiscal interest in making sure that their RAC programs are high quality, not just “fishing expeditions.” You may also want to carbon copy your appeals letters to your state medical society, your AAP chapter, and/or your state’s Pediatric Council, being careful to avoid sensitive information such as patient information or a reference to your charges for a given service.

10) **How can you be confident you can survive a RAC edit well?** Know your payer coding rules. Keep copies of correspondence regarding coding guidelines from year to year to refer to as needed for past claims. Make sure your practice understands best coding practices including key items such as when to use a new patient code, correct use of modifiers, and that your providers having a good knowledge of level of E/M coding rules. The Academy’s Coding Resources provide members with a wide range of coding publications and tools designed to accurately capture services & ensure timely payment. [http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/default.aspx](http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/default.aspx)

11) **Additional AAP RAC Resources**
   a. *What to do when an auditor knocks on your practice’s door,* AAP News, October 2013: [http://aapnews.aappublications.org/content/34/10/18.full.pdf+html](http://aapnews.aappublications.org/content/34/10/18.full.pdf+html)
   b. *Compliance programs: preventive medicine for business side of your practice,* AAP News, August 2013: [http://aapnews.aappublications.org/content/34/8/1.1.full.pdf+html](http://aapnews.aappublications.org/content/34/8/1.1.full.pdf+html)