

# RAC or RECOVERY AUDITOR CONTRACTOR

Website [www.cms.hhs.gov](http://www.cms.hhs.gov)

## Glossary of terms:

**RAC Recovery Auditor Contractor**, work to identify inappropriate payments made to physicians and other providers, can request a limited number of medical records, e.g. 10 medical records per 45 days per NPI (National Provider Identifier) for solo practitioners; 20 medical records per 45 days per NPI for partnerships of 2-5 individuals; 30 medical records per 45 days per NPI for groups with 6-15 individuals; and 50 medical records per 45 days per NPI for large group practices. Appeals must be filed by 120 days (and received at the correct address), but after 30 days, the appeal will not stop the recoupment of money by the RAC. [the number of charts that can be requested is being lowered and it appears that RAC can only go back to October of 2007]

**LCD Local Recovery Decisions**

**CAC Carrier Advisory Committee**

**MMA Medicare Prescription Drug, Improvement and Modernization Act of 2003**

(President Bush December 8, 2003, allowing CMS to change Medicare FFS program's administrative structure to allow competitive, performance-based contracts)

**MAC Medicare Administrator Contractors**, 19, 15 of which service Parts A and B  
And 4 for durable medical equipment suppliers

**NCD National Coverage Decisions**, come from CMS, based on scientific studies and data collected, but will reconsider with new data, may specify services always or never covered, published in CMS Coverage Manual, may change with changes in law

**CMS Centers for Medicare and Medicaid Services**

## **THE NEW STRUCTURE FOR DECISIONS:**

### **How are LCDs reconsidered?**

**Local Recovery Decisions** have a cut over date, after which reconsiderations may take place at the mandated 3 CAC meetings per year

--decisions posted on websites with connections to CMS Medicare Data Base

--Your local medical societies have input on the LCDs , which give codes an conditions for payment, and may state frequency of service and diagnoses. The societies do not determine the decisions, but are asked to give input in a letter by 30 days.

### **What if I have a case that requires exception?**

If you have an unusual case or exception, document,

### **What if I think that the LCD will not cover the care?**

If you believe that Medicare is likely not to pay for the service, have the patient sign the 2009 ABN (Advanced Beneficiary Notice), downloadable from [www.cms.hhs.gov/bnl](http://www.cms.hhs.gov/bnl)

--“gy” is a denial and “gz” means beneficiary will not sign, in which case you and one other office person sign the form

### **How do I request a reconsideration of denied payment due to LCD?**

Send your request within 30 days to the local Contractor (MAC), stating why the denial is wrong. Add supporting scientific evidence, such as literature in peer reviewed journals, expert opinion from credible sources, guidelines/statements from specialty societies, or results of medium or long term studies. Be specific by use of CPT, ICD-9, organ systems or special circumstances. Be conscious of vested interests. Contractor must respond in 30 days.

--Check to see if you coded correctly.

--Check national or local coverage policies.

--Make sure to send reconsideration request to the specific address for reconsideration

--you may need to speak to the group asking for records, if so ask for the name of someone, note down who you asked and what you asked for

--ask assistance from the state society

--YOU ARE ENCOURAGED TO APPEAL IF YOU THINK YOU HAVE GROUNDS

### **How do I document?**

Try to paint a picture that explains what you are doing: how the patient is doing/what is new during higher code visit/unusual or atypical drugs, labs, or diagnostic tests/need for frequent visits or higher e&m visits/any special problems with that individual patient/observations and supportive data, as needed

Can they read the writing?

Include name, date, time, identification, and signature on chart

If using templates or forms, individualize for each patient or visit

Medical necessity still rules when being reviewed

If you utilize electronic medical records and must add a paper record, announce in your dictation that it is coming

### **What if I am asked for records?**

--Get the NAME and GROUP asking for the records! The group asking may determine how you respond with specific test results vs medical record

--Do the asking yourself. You, not the office staff, should talk to the requestor and you should call to make sure that they got the records.

--Remember that RAC is paid a percentage of what money is returned.

- send unadulterated original, make additions by all means, but admit that you did it (time/date)
- If document not legible, rewrite it right
- send it on time
- make sure that you send it to the right place
- when the document reaches the MAC, it will be first sent to a nurse and then a physician

### **What are my rights to appeal?**

- Appeal, appeal, appeal; go to the higher source—you are entitled to be paid for what you do and each appeal level leads to a fresh perspective
- usually you will win if you give enough documentation, and there is no limit to the monetary return or penalty for appeals
- six ways to appeal: 1) initial determination by MAC, 2) Redetermination by MAC, 3) Reconsideration by QIK, 4) Administrative Law Judge reviews, 5) Medicare Appeals Board, 6) Federal Court
- appealing helps the MAC avoid making mistakes, refines the process
- it is good to check with colleagues for opinions when appealing

What information must I give to call or write for information?

NPI, Provider transaction number, last five digits of tax identification

### **How do I keep up with changes?**

- CMS will have an alert every month to every other month to advise of changes, you will need to sign up.
- Keep membership in state and specialty organization and review their alerts and websites/newsletters
- consider the power of OPAC/MOPAC contributions
- employ people who understand coding and billing rules and communicate with them regularly
- update coding books regularly
- review PQRI, electronic prescribing, electronic medical record and other Medicare enhanced reimbursement programs to see if they are right for your practice
- do not under-code! It is as dangerous as over-coding
- while a physical exam is not paid by Medicare, except for the new enrollee, you can document chronic disease or risk factors, such as a history of cancer, which may improve the evaluation and management code