The RAC Toolkit
for Physician Practices

Protecting Your Bottom Line Under Medicare's Recovery Audit Contractor Program

ELIZABETH E. LAMKIN, MHA
AMANDA W. BERGLUND, MS, MBA

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About the Authors

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Elizabeth Lamkin has more than 20 years of executive experience in the nonprofit, clinical teaching, and investor-owned healthcare sectors. She served as market president and CEO for Hilton Head Regional Healthcare (Tenet) where she developed a successful Recovery Audit Contractor (RAC) strategy during the demonstration project. Prior to that, she held positions as chief operations officer for North Fulton Regional Hospital (Tenet) in Roswell, GA; regional CEO for four inpatient hospitals for HEALTHSOUTH in Arizona; CEO for HEALTHSOUTH in Charleston, SC; and served as administrator for Palmetto Health Heart Hospital in Columbia, SC. She is currently CEO of PACE Healthcare Consulting, LLC, which provides a broad range of strategic and tactical services for hospitals and healthcare providers. Lamkin holds a bachelor of arts cum laude and a master's in health administration from the University of South Carolina. Because of strong operational, quality, and strategic successes, Lamkin brings a unique, global CEO perspective to surviving RAC audits and other billing compliance issues.

Amanda W. Berglund, MS, MBA, COO, PACE Healthcare Consulting, LLC

With more than 10 years of experience in healthcare and biotechnology, combined with degrees in business and engineering, Berglund works with clients on projects that require detailed analysis, systematic business case development, comprehensive implementation, and continued measurement. Prior to joining PACE Healthcare Consulting, LLC, Berglund was chief business development officer at North Fulton Regional Hospital in Roswell, GA, where she was responsible for all aspects of business development. She has also worked in Arthur Andersen's healthcare consulting division, where her projects included strategic planning, revenue-cycle development, cost containment strategy development, and policy manual development. Berglund holds a bachelor of science degree from Columbia University, a master's of science degree from Georgia Institute of Technology, and a master's degree in business administration from Nova Southeastern University.
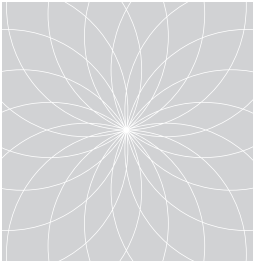
Acknowledgments

Deborah Burke, MHA, FACHE, for her advice and guidance. Burke is the owner and principal of Phoenix Healthcare Consulting Group, Deborah focuses her attention on group practice management. With over 25 years experience in healthcare management in both non-profit and for-profit setting, Burke brings functional expertise in all aspects of healthcare management to include strategic planning, finance, practice and administrative operations, practice and organizational development including new practice start-up.

David Clayton, president of Chaos Design, Software Development Partner to PACE Healthcare Consulting, LLC for his dedication to the RAC Tracking and other RAC related software development. Clayton worked with the authors to develop software when it was discovered that so many hospitals and health systems were using homegrown software or basic spreadsheets to track the RAC process.

Randy Lamkin, PhD, for his help in understanding what makes an effective meeting. Lamkin earned a PhD in sociology from the University of Connecticut and has taught at the University of South Carolina (USC) in Columbia, USC-Beaufort, the College of Charleston, and Scottsdale Community College. He was president of an organizational development and training company specializing in team building, planning, and quality improvement, and also served as Director of Educational Services at Richland Memorial Hospital in Columbia, SC.

Bill Malm, ND, for his collaboration on the development of this material and his partnering with Elizabeth Lamkin on several nationally broadcast webinars on the Recovery Audit Contractor (RAC) process. Malm works with CraneWare, Inc., and is a nationally known author and speaker on topics such as compliance, Chargemasters, and postpayment recoupment audits.
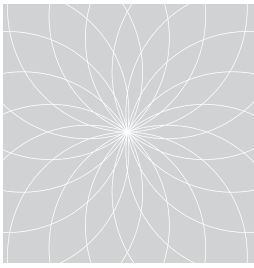
Introduction: A Successful Approach to RAC Is Driven From the Top

If you are reading this book, you understand that the Recovery Audit Contractor (RAC) program has tremendous implications for your practice's financial viability. The Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) will continue to expand the RAC program and compliance requirements associated with it. The environment in which we practice has changed dramatically. Federal money is being allocated to detect fraud and abuse but also to eliminate waste. In the case of RAC, the systems to detect fraud and abuse are also used for finding overpayments or waste. RAC has the ability to report potential fraud and abuse to the OIG in addition to simple billing errors. All CMS providers are at risk for takebacks.

Since we began this, our second book on RAC, CMS has released an update on RAC activity through third quarter 20ll. See *www.cms.gov/Recovery-Audit-Program/Downloads/FFSNewsletter.pdf*. In a related article, *RAC Monitor* reported that CMS is behind on its fiscal goals for 2011 and will most likely try to make up ground in fourth quarter 2011. "FY 2011, fourth quarter—(July 2011–September 2011)—To meet CMS's FY 2011 goal an additional $307.5 million in billed services needs to be corrected."[1]

The point is, audits will not go away; they will instead increase. And although there has been sensitivity to physician practices in the past, we believe the next wave of audit scrutiny will hit everyone. Anecdotally, we hear physicians are not consistently supplying contact information to regional RACs and that they feel the risk for them is low. That is no longer the case, and if you have not provided your contact information you will miss any window for discussion and take backs will simply occur. What follows is more information on the how the government views the situation.

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1. Source: Axsom-Brown, Vickie; RAC Monitor. "RAC Falls Short in the Third Quarter by $82.5 Million," Accessed August 15, 2011. *www.racmonitor.com/news/3-feature-articles/624-racs-fall-short-in-third-quarter-by-825-million.html?showall=1.*

Introduction

On March 4, 2011, Daniel R. Levinson, Inspector General, testified to the House Appropriations Committee's Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. Excerpts from this testimony follow, which point to the intensity with which the federal government is pursuing fraud and abuse. RAC is only one program used; the government and RAC take their lead from the OIG.

"OIG fights health care fraud, waste, and abuse through a nationwide program of investigations, audits, evaluations, and enforcement and compliance activities. Our FY 2010 appropriation included approximately $232 million in funding dedicated to protecting the integrity of Medicare and Medicaid. In recognition of the value and impact of OIG's oversight and enforcement activities, the President's Budget for FY 2011 requests approximately $272 million in Medicare and Medicaid integrity funding for OIG, a net increase of $40 million. With this increased funding, OIG will expand its activities in support of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (known as HEAT ...), including expanding the OIG-DOJ Medicare Fraud Strike Forces to 13 new locations.

OIG's funding is used to hire and support investigators, auditors, evaluators, attorneys, and management and support staff to carry out [its] mission and functions. OIG is comprised of more than 1,500 professionals who perform comprehensive oversight and enforcement activities for HHS programs . . .

Waste and abuse cost taxpayers billions of dollars and must be addressed. Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In FY 2009, CMS estimated that overall, 7.8 percent of the Medicare fee-for-service claims it paid ($24.1 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. For [its] part, [the] OIG reviews specific services, based on ... assessments of risk, to identify improper payments. For example, an OIG audit uncovered $275.3 million in improper Medicaid payments (Federal share) from 2004 to 2006 for personal care services in New York City alone. An OIG evaluation of payments for facet joint injections (a pain management treatment) found that 63 percent of these services allowed by Medicare in 2006 did not meet program requirements, resulting in $96 million in improper payments."[2]

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2. Source: OIG. "Testimony of: Daniel R. Levinson, Inspector General, U.S. Department of Health and Human Services." (2010). Accessed August 7, 2011. *http://oig.hhs.gov/testimony/docs/2010/3-4-10LevinsonHAppropsSub.pdf.*

Introduction

Our goal in writing this book is twofold: (1) to help practices effectively approach, prepare for, and respond to individual RAC audits; and (2) to help practices improve the overall billing compliance program through specific changes to their organizations' structures, processes, and people. It is this second purpose that requires changes that must be championed by the leaders within the practice. The magnitude of the financial, licensure, and compliance risk associated with RAC and improper billing elevates RAC to a concern for the top leadership of the organization, but everyone in the organization needs some education on the program to ensure that any changes implemented to deal with RAC and other government priorities are effective and sustainable.

The practice administrator has the responsibility to report all compliance issues and potential risk to the physicians practice board (PPB). Top leadership should drive the RAC process because it is not just the repayment of improper claims that are at stake for an organization, but it is the greater risk of being out of compliance with CMS regulations that could lead to sanctions, fines, corporate integrity agreements, etc. The practice administrator and PPB are responsible for the financial health of the organization as well as for implementing an effective compliance program.

The practice administrator, as a part of the compliance program, must educate the PPB on the False Claims Act (FCA) because, even if incorrect bills are unintentional, the FCA may still apply. Following are excerpts from the FCA from CMS' website:

> *"For purposes of this section [of the False Claims Act], the terms 'knowing' and 'knowingly' mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.*
>
> *While the False Claims Act imposes liability only when the claimant acts 'knowingly,' it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable."*[3]

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3. Source: CMS. "False Claims Act (FCA)." (n.d.). Accessed November 25, 2010. *www.cms.gov/smdl/downloads/SMD032207Att2.pdf.*

Although the PPB will not directly manage RAC-related efforts, only the PPB and practice administrator can prioritize RAC and billing compliance and provide the resources required to meet the government obligations. When allocating resources, the practice administrator has the advantage of a global perspective. It is critical to involve high levels of the entire leadership team because compliant billing will involve all aspects of the organization, including the physicians. Only leadership can effectively drive change and knock down silos.

Even as we write this book, the RAC program continues to change and evolve, and although there are many resources available for individual and code-level issues related to RAC (the micro level), we will focus on a macro, systemic approach to RAC readiness to build a compliant organization that communicates effectively and strives for continual improvement. We wish to demonstrate how all parts of the organization fit together for billing compliance while providing the tools to approach and respond to individual audits.

An Ounce of Prevention Is Worth a Pound of Cure

For those of us with many years of healthcare experience, we know that every decade or so, we are faced with new rules that require a significant retooling of our systems in order to adapt and thrive. Now we have expanded postbilling Medicare audits with serious compliance and financial consequences if errors are found. The RAC program is not a one-time audit; it is a permanent program across the United States. RACs will soon be expanding to Medicaid. This is in addition to the Medicaid Integrity Program, in which CMS has contracted with Medicaid integrity contractors much the way they have contracted with RACs. CMS initially required that states fully implement a RAC program by April 2011, but in a bulletin issued in February 2011, CMS indicated that the deadline has been extended. The new deadline is expected to be published by CMS sometime this year.[4]

After successfully navigating the RAC demonstration project in South Carolina and carefully studying the changes that were made to the program, we have designed this book as a toolkit that we hope will give you a framework with which to successfully approach the RAC process and minimize recoupments by CMS. Because there are so many variables involved across every organization, we cannot guarantee individual practice results.

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4. Source: Budetti, P., and C. Mann. CPI – CMCS Informational Bulletin. "Clarification of CMS expectations for state implementation of Medicaid recovery audit contractor (RAC) programs." (2011). Accessed March 6, 2011. *www.nebmed.org/uploadedFiles/RAC%20delay.pdf.*

> Critical to approaching RAC or other audit programs is to be proactive in creating and maintaining a compliant organization rather than waiting until an audit to act. As you read this book, two themes regarding compliance will stand out:
>
> 1. The practice administrator, hand-in-hand with the PPB, must understand and drive the process from the top.
>
> 2. Each practice needs the right structure, process, and people to manage the operations function of billing compliance.

By continually self-regulating its own compliance, the organization is far less vulnerable to RAC overpayment recoupments or other potentially serious compliance problems. Although we focus on RAC and billing compliance, the systems contained herein can be the foundation for dealing with an ever-changing billing regulatory environment and third-party payers that quickly follow CMS' lead when it comes to billing and payments.

To be successful, approach RAC as you would any significant performance improvement (PI) project. With planning, the right systems, and good audit tools you will be prepared for a RAC audit before you receive your first RAC request for records. Too many practices take a "wait and see" approach without assessing and quantifying their own risk. By doing so, they set the organization up for failure upon appeal, if they have the ability to appeal at all.

> All providers, regardless of size, should operate as if they will soon receive a request for records or a demand letter from their RAC. Because the RACs are set up as permanent entities and because there is no limit to the number of audits and providers they review, their growth potential is enormous.

Unfortunately, once you receive a postaudit demand letter claiming overpayments were made, there are only two possible outcomes for each claim:

1. Your documentation and coding will support the billing claims.

2. Your documentation and coding will not support the billing claim.

If you find your practice cannot support the billing claim with existing documentation, all you can do is refund the overpayments back to CMS and implement a PI process to correct errors so as to be compliant with CMS billing in the future. If, however, your documentation supports the billing claims, you have a legitimate reason to appeal any RAC claims of overpayment. One thing is certain: RAC and similar audits are here to stay; therefore, you must have a permanent system of billing compliance improvement in place.

Billing might be the most complicated, nonclinical system in healthcare because multiple functions must be performed correctly over many diverse departments and locations. In addition, some of the functions under billing often feel as if they are out of our control, such as the variety of clinical documentation. Other functions are directly out of our control, such as the ever-changing regulatory environment. The RAC program adds a level of scrutiny to billing compliance that requires understanding and cooperation between billing areas and clinical departments in a far more direct approach than ever undertaken previously. It demands knowledge and engagement of frontline staff and physicians regarding billing issues they may have previously seen as outside the scope of their job. In fact, clinical staff may actively reject involvement.

This book provides a more detailed description of resource allocation to front-end prevention versus the back-end processes of error correction. This will ultimately result in fewer resources to correct errors and reduce RAC audit vulnerability.

Because of the enterprisewide scope needed to maintain billing compliance, we advise you not to relegate your RAC preparedness program to the business office teams alone. Although revenue cycle personnel have important roles to play, RAC and postbilling audits are critical issues for the entire leadership team because of the magnitude of risk and complexity of compliant billing. Success requires leadership and priority setting from the practice administrator and solid operation performance from staff. Only the practice administrator can eliminate turf wars and staff push back that may otherwise endanger success. The practice administrator must recognize the importance of RAC and place resources where they are needed.

Reading This Book

This book is designed to walk you through RAC preparedness and response in the following way:

1. Introduce the RAC program (Chapter 1)

2. Begin a discussion on RAC preparedness (Chapter 2)

3. Detail a suggested RAC-ready structure through committee creation (Chapter 3)

4. Discuss the RAC impact on key stakeholders (Chapter 4)

5. Provide detail on the two types of RAC reviews (Chapters 5 and 6)

6. Detail the appeals process (Chapter 7)

If you picked up this book because you just received a request for records or a demand letter, skip the RAC committee section in Chapter 3 and go to the chapters focused more on RAC response than RAC preparedness, which are Chapters 5 though 7.

However, if you skip to the appeals section to get through your first RAC audit, we hope you will look to the rest of the book to help you restructure your organization to prepare for future audits. If you are constantly in the mode of "response" as opposed to "preparedness," you set yourself up for a long road of multiple audits for the same issues.

Keep in mind that CMS may, along the way, change some of the rules and requirements of the program (e.g., documentation limits, deadlines, submission guidelines), so it is essential that you keep up-to-date with any changes to the program. Throughout the book, we provide suggestions, websites, contact information, and resources to help you stay current on programmatic changes.

> As with any healthcare book, we will use many acronyms. The Appendix provides a list of acronyms used in this book. Throughout this book, the acronym "RAC" refers both to the Recovery Audit Contractors that have been engaged by CMS to perform RAC audits and to the *process* of RAC itself. Using RAC to refer not only to the contractors but also to the entire process has become common across the industry in articles and other forums.

DOWNLOAD YOUR MATERIALS NOW

Physician practice settings are being audited by RACs. Whether you're dealing with a RAC or another government auditor, you need a program that's running as effectively as it can be. Use the authors' proven and practical tools to build a more effective billing compliance program. Learn how to bring finance, business office, and other critical groups together for operational improvements that drop right to the bottom line.

The RAC Toolkit for Physician Practices will help you get the job done right.

Among the tools you can download are:
- RAC appeal timeline
- RAC preparedness checklist
- RAC committee structure flowchart
- Organizational chart for RAC-related personnel
- Sample RAC committee meeting agenda
- Complex case review worksheet
- Automated review timeline
- Complex review timeline
- CMS form 20027
- CMS form 20033
- CMS form 20034
- CMS form DAB101

Website available upon purchase of this product.

Thank you for purchasing this product!

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1

RAC Overview

RAC audits have become synonymous with the Centers for Medicare & Medicaid Services (CMS) audits; however, they are only the tip of the iceberg, and with the current crisis around rising provider costs for Medicare and Medicaid, audits are a permanent part of the healthcare billing and reimbursement landscape.

> Although the focus of this book is RAC, we recognize the need for physicians to maintain and enhance revenues in this challenging reimbursement environment. To that end, we will also discuss the overall compliance environment as it pertains to physician practices. Now is the time to focus on capturing every dollar you are legally entitled to and to correct errors in your own systems that result in underbilling or CMS takebacks for overbilling.

Up until now, most RAC discussions and education have focused on Part A providers, which ultimately resulted in improvements in Part A hospital revenue cycle. As part of revenue cycle improvements, hospitals have improved clinical documentation and the bottom line. Part A providers have also learned that improved documentation improves both patient care and reimbursement. As we expand our discussion to include physician practices and other outpatient providers, the lesson for physicians is to use RAC as a platform for global practice improvement measures.

Since our first book on RAC was published in May of 2011, we continue to hear from practice managers and coding companies that there is a disconnect between those who are coding and those who are documenting care, resulting in reduction for a practice's bottom line. Although our *RAC Toolkit for Hospitals and Health Systems* can help with Part B billing, we decided to create a more specific, targeted toolkit for physician practices. By paying attention to RAC and your own revenue cycle, physician practices will find areas of undercoding and simple errors that reduce reimbursement.

On a related note, in 2011, physicians may also improve reimbursement through reporting of quality indicators. The incentive payment is 1% for 2011 and 0.5% for 2012 through 2014 (subject to CMS rules and regulations).[1] The reason we point this out is that quality reporting is consistent with a good revenue cycle program, and a good revenue cycle program starts with good documentation practices. In addition, payments from these incentive programs can be used to offset the costs of not only a quality electronic health record (EHR) program but also RAC audit tools such as a tracking system or third-party assistance with RAC preparedness.

By improving quality reporting, you are also improving documentation needed for RAC. The following excerpt from the CMS website explains the quality incentive further.

> *"2011 Physician Quality Reporting. To participate in the 2011 Physician Quality Reporting, individual eligible professionals [or group practices] may choose to report information on individual Physician Quality Reporting quality measures or measures groups: (1) to CMS on their Medicare Part B claims, (2) to a qualified Physician Quality Reporting registry, or (3) to CMS via a qualified electronic health record (EHR) product. Individual eligible professionals who meet the criteria for satisfactory submission of Physician Quality Reporting quality measures data via one of the reporting mechanisms above for services furnished during a 2011 reporting period will qualify to earn a Physician Quality Reporting incentive payment equal to 1.0% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period."[2]*

Another Medicare incentive payment program is the EHR "meaningful use" incentive program. For each year under the incentive program, an eligible professional may receive 75% of their total "allowed charges" (i.e., Medicare physician fee schedule [PFS] payments) during the payment year, subject to a cap. The caps are shown in **Figure 1.1.** The first year amount is prorated based on when the professional began "meaningful use" of an EHR system.

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1. Source: CMS. "Physician quality reporting systems, analysis and payment." (n.d.). Accessed July 22, 2011. *www.cms.gov/PQRS/25_AnalysisAndPayment.asp#TopOfPage.*

2. Source: CMS. "Physician quality reporting system, overview." (n.d.). Accessed July 22, 2011. *www.cms.gov/PQRS/.*

Figure 1.1	Medicare EHR Incentive Payment Schedule for Eligible Physicians				

Payment Amounts	If a Medicare Eligible Professional Qualifies to Receive First Payment in 2011	If a Medicare Eligible Professional Qualifies to Receive First Payment in 2012	If a Medicare Eligible Professional Qualifies to Receive First Payment in 2013	If a Medicare Eligible Professional Qualifies to Receive First Payment in 2014	If a Medicare Eligible Professional Qualifies to Receive First Payment in 2015
Payment Amount for 2011 Will Be	$18,000				
Payment Amount for 2012 Will Be	$12,000	$18,000			
Payment Amount for 2013 Will Be	$8,000	$12,000	$15,000		
Payment Amount for 2014 Will Be	$4,000	$8,000	$12,000	$12,000	
Payment Amount for 2015 Will Be	$2,000	$4,000	$8,000	$8,000	
Payment Amount for 2016 Will Be		$2,000	$4,000	$4,000	
Total Payment Amount Will Be	$44,000	$44,000	$39,000	$24,000	

Source: CMS. "Medicare and Medicaid EHR incentive program basics." (n.d.). Accessed July 22, 2011. www.cms.gov/EHRIncentivePrograms/35_Basics.asp#BOOKMARK2.

Eventually, all physician offices will be required to report electronically. Physician practices are challenged to meet the criteria necessary to receive all incentive payments and to avoid penalties beginning in 2015. Although most practices have adopted or plan to adopt an approved EHRs, many lack the time and knowledge to implement the workflow changes necessary to meet the quality measures. Deborah Burt, owner of Phoenix Healthcare Consulting Group in South Carolina, suggests that practices look to their state Regional Exchange Center (REC) for assistance. The services are currently offered at no cost to practices who meet certain criteria. The REC program is made possible from grants from the federal Department of Health and Human Services (HHS) through the Office of the National Coordinator for Health Information Technology. The purpose of the program is to provide education and consulting on effective strategies and practices to select, implement, and meaningfully use certified EHR technology to improve the quality and value of healthcare. Additionally, Burt adds that successful practices have learned that external resources are and will continue to be a critical element of practice operations and management in the future. Additional information on RECs can be found at *http://healthit.hhs.gov*.

In addition, we recommend you explore other opportunities in your state and region to take advantage of the money earmarked to help physicians meet "meaningful use" criteria. Links to additional resources related to EHR and meaningful use follow. The last link is for a tutorial on the program from CMS' YouTube channel: *CMSHHH.gov.*[3]

- *www.healthsciencessc.org/index.php/more/citia-sc*

- *http://healthpolicyandreform.nejm.org/?p=3732&query=OF*

- *www.cms.gov/EHRIncentivePrograms/*

- *www.youtube.com/user/CMSHHSgov#p/u/2/aKCXk4FAwIA*

The RAC Program

As stated by CMS, the mission of the RAC program is to find and correct previous improper payments and to implement changes that will prevent improper payments in the future. CMS has contracted with RACs to help the agency achieve its mission and has given RACs the power to audit Medicare claims for a quickly growing list of issues across multiple provider types to recover these improper payments.

As you are probably aware, CMS and other payers are not the only groups scrutinizing how provider bills are paid. The public is becoming increasingly aware of Medicare costs and how the government is attempting to reduce those costs. Taxpayers want to ensure that Medicare costs are minimized, and Medicare recipients want assurances that benefits will not depreciate at worst and, at best, they hope to see Medicare and Medicaid benefits possibly even improve. CMS has started a public awareness campaign that includes a focus on Medicare fraud and recoupments. In a 2010 advertisement, TV star Andy Griffith touts the benefits of the "new healthcare law." In it, he says that 2011 will bring Medicare participants "better ways to protect us and Medicare from fraud," while "Billions Recovered So Far" flashes at the bottom of the screen.[4] This seems to refer directly to the recoupments from the RAC demonstration project, in which RACs made approximately $1 billion in overpayment claims. Clearly, from a marketing perspective, CMS is applying the word "fraud" to coding and documentation errors, not just bold "gaming" of the system.

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3. All links listed were accessed July 23, 2011.

4. Source: CMS. "1965 music to my ears." (n.d.). Accessed July 1, 2011. *www.youtube.com/watch?v=SbqwT3lJdnA.*

Although we focus on the RAC program in this book, the overarching issue is billing compliance. The Affordable Care Act (ACA) will broaden compliance program requirements and self-reporting requirements (60 days for reporting internal findings) for providers and will expand RAC into Medicaid, Medicare Advantage, and Part D (drug benefits). We expect new guidelines for compliance will be issued as the focus on Medicare fraud and abuse expands with increased penalties.

Links to articles on the ACA and to the current compliance program requirements issued by the Office of Inspector General (OIG) include:

- HealthcareReform.gov, "The Affordable Care Act: New tools to fight fraud, strengthen Medicare and protect taxpayer dollars" *www.healthreform.gov/affordablecareact_summary.html*

- OIG, "Compliance guidance" *http://oig.hhs.gov/fraud/complianceguidance.asp*

What Are RACs and What Do They Do?

Throughout the book, we will frequently refer to the RAC section of CMS' website (*www.cms.gov/recovery-audit-program/*) where you can find updates to the program. We have noticed that some documentation on this site is outdated and some links are invalid, so please be sure you first go to the "Recent Update" section of the site, which should have the most current information. You can also contact CMS or the RAC assigned to your region by e-mail or by phone with questions or for clarification of an issue. CMS recommends you first go to your RAC for information.

CMS has contracted with the following four RACs—each assigned to a different region of the United States. We will include contact information for your convenience, but you should always confirm that both the physical and e-mail addresses as well as phone numbers are accurate and that every letter, e-mail, or voice mail was received by the RAC. This is important because if the RAC claims they did not receive your documentation and you have no record of sending it, you are at significant risk for a denial.

Region A

Diversified Collection Services, Inc. (DCS)

www.dcsrac.com/PROVIDERPORTAL.aspx

333 North Canyons Parkway, Suite 100

Livermore, CA 94551-7661

E-mail: *info@dcsrac.com*

Phone: 866/201-0580

Region B

CGI Technologies and Solutions, Inc.

http://racb.cgi.com

11325 Random Hills Road

Fairfax, VA 22030-6051

E-mail: *racb@cgi.com*

Phone: 877/316-7222

Region C

Connolly, Inc.

www.connollyhealthcare.com/RAC

50 Danbury Road

Wilton, CT 06897

E-mail: *RACinfo@connollyhealthcare.com*

Phone: 866/360-2507

Region D

HealthDataInsights, Inc. (HDI)

https://racinfo.healthdatainsights.com

7501 Trinity Peak Street, Suite 120

Las Vegas, NV 89128-6896

E-mail: *racinfo@emailhdi.com*

Phone: Part A: 866/590-5598

Part B: 866/376-2319

The following map shows which states are assigned to each RAC (**Figure 1.2**). Depending on how many locations you have, you may receive multiple requests from a single or from multiple RACs. You will receive a records request only for cases to be reviewed under the complex or semiautomated audits. For automated

audits, there will be no request for records, and you will not know which cases were reviewed unless you receive a demand letter. Any claims of improper payments will be made in the demand letter, but you will not be notified at all of automated cases that were reviewed but that "passed" improper payment tests.

> Although not described in the original RAC Scope of Work,[5] in 2011, the RACs started doing "semiautomated" audits in which, after an automated review of claims, the RAC sends a notification letter requesting additional documentation to support the claim. A semiautomated review may take place when the RAC finds a possible error and is looking for additional information to determine if a denial can be made.[6]

| Figure 1.2 | CMS Map Showing Contractor Regions |
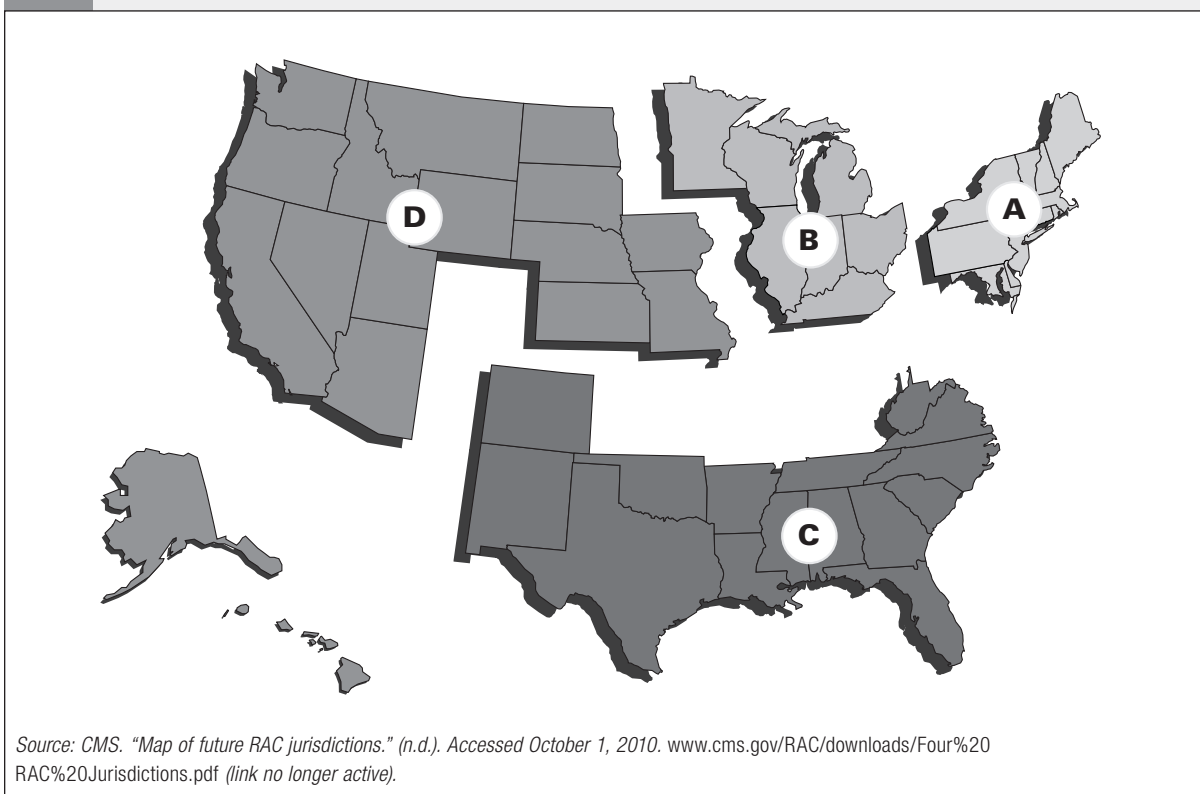
Source: CMS. "Map of future RAC jurisdictions." (n.d.). Accessed October 1, 2010. www.cms.gov/RAC/downloads/Four%20 RAC%20Jurisdictions.pdf *(link no longer active).*

5. Source: CMS. "Statement of work for the Recovery Audit Contractor program." (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/ Downloads/RACFinSOW.pdf.*

6. On their support page, CMS expanded on the meaning of a semiautomated review. For information, see: *http://questions.cms.hhs.gov/app/answers/detail/a_id/10430/ kw/semi-automated/.*

CMS has also approved the following subcontractors to assist the RACs with complex reviews:

- PRGX Global, Inc. (formerly PRG-Schultz, Inc.) as a subcontractor in Regions A, B, and D

- Viant Payment Systems, Inc., as a subcontractor in Region C

- iHealth Technologies and Strategic Health Solutions as a subcontractor in Region A

To ensure accuracy of the RAC process, CMS added a RAC validation contractor (RVC) because of concerns that the RACs may not interpret CMS rules properly. For the permanent program, CMS announced that the RVC would be Provider Resources, Inc. According to the "Recent Updates" section of the CMS RAC website, the RVC *"will work with CMS and the RACs to approve new issues the RACs want to pursue for improper payments, as well as perform accuracy reviews on a sample of randomly selected claims on which the RACs have already collected overpayments."*[7]

According to CMS, the keys to success of the program are that the provider burden is minimized, accuracy is ensured, and transparency is maximized. Some examples of minimized provider burden are that only approved issues can be audited, records can be scanned rather than sent as hardcopy, and the number of medical records requested is limited. However, the RACs will be able to look back up to three years prior to a claim being paid and may request additional records through CMS for audited claims. RACs will also be able to extrapolate errors found during an audit across three years. We discuss extrapolation in more detail in Chapter 6.

For additional detail of what the RACs can and cannot do, you can download the lengthy "Statement of Work for the Recovery Audit Contractors" from the CMS website.[8] In it, the RACs are tasked with identifying "vulnerability issues"—the issues on which they can base a claim of over- or underpayment—then CMS, with the help of the RVC, will decide whether to approve these issues. Although each RAC has its own issues list, you can be sure that individual RACs are closely monitoring the issues approved for other RACs and will explore the issue for their own audits.

7. Source: CMS. "RAC recent updates." (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Recent%20Updates.asp#TopOfPage.*

8. Source: CMS. "Statement of work for the Recovery Audit Contractor program." (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Downloads/RACFinSOW.pdf.*

> If you have examples of a RAC not meeting the requirements set by CMS, keep track of them, and consider reporting them to CMS, or to your local Medical Group Management Association (MGMA), or to the American Hospital Association. Examples may be missed deadlines on the part of the RAC, incorrect information on the online claim status tool, requests for records previously audited by another governmental body for the same issue, failure to supply reviewer credentials if requested, etc. Unfortunately, even if these "contractual obligations" are not met, you may still be liable for the denial.

One way issues will be added will be through sophisticated data mining to identify outliers across several types of organizations. If outliers or suspect claims are found in the data mining process, RACs may perform "probe audits" of up to 10 cases from a provider to further identify whether problems exist and to develop a case for the issue. Record requests for these probe audits (or "test claims") do not count toward the record request limits set by CMS for individual providers, but no additional records can be requested related to a specific issue until after the issue is approved by CMS.[9]

To explain further, the "issues" are any areas where CMS, the RVC, and the RAC believe there is a vulnerability that allows for improper payments. Although RACs are charged with identifying over- and under-payments, only a very small portion of the issues will likely identify and address underpayments. In fact, in the demonstration project, only 4% of identified improper payments were underpayments (see **Figure 1.3**). For the most part, this is because the process lends itself to finding postclaim errors, which are usually overpayment related. Underpayments are more often a result of not capturing charges or of "undercoding," which would not necessarily be identified in the postclaim documentation.

9. Other sources indicate that the 10 test claims do count toward additional documentation request (ADR) limits, but we confirmed in a telephone call to DCS customer service on December 21, 2010 (phone number: 866/201-0580), that these test cases remain a separate documentation request and do not apply to the facility's ADR limit unless, after the issue is approved, all or some of these records are included in the complex audit review, but the RAC will indicate such in the request letter.

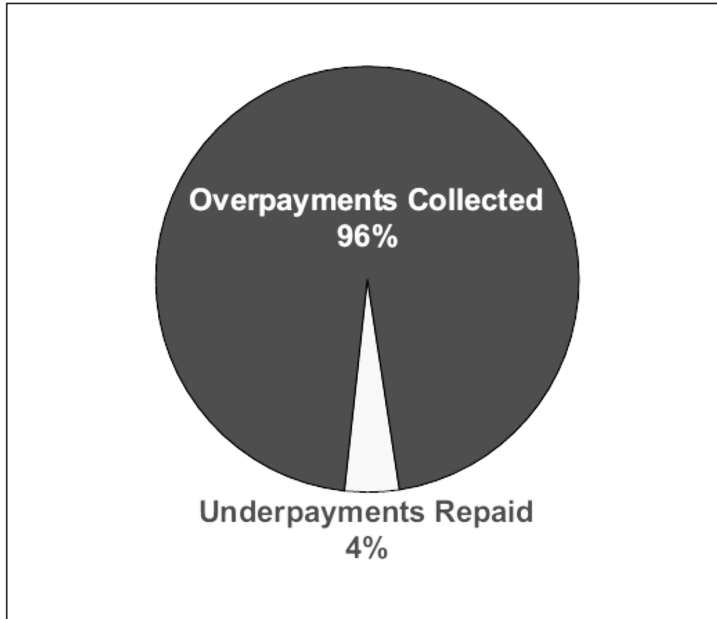| Figure 1.3	Overpayments vs. Underpayments From Demonstration Project

Overpayments Collected
96%

Underpayments Repaid
4%

Table 4. Improper Payments Corrected by the RAC Demonstration: Cumulative Through 3/27/08, Both Claim RACs and MSP RACs
(Million Dollars)

RAC	Overpayments Collected[a]	Underpayments Repaid[b]	Total Improper Payments Corrected
Connolly	$ 266.1	$ 4.3	$ 270.4
HDI	$ 396.1	$ 20.8	$ 416.9
PRG	$ 317.8	$ 12.7	$ 330.5
Claim RAC Subtotal	*$ 980.0*	*$ 37.8*	*$ 1,017.8*
HMS	$ 1.3	$ 0.0	$ 1.3
DCS	$ 11.4	$ 0.0	$ 11.4
MSP RAC Subtotal	*$ 12.7*	*$ 0.0*	*$ 12.7*
Grand Total	$ 992.7	$ 37.8	$ 1,030.5

[a]Collected is defined as overpayments that have been recovered from providers and deposited.
[b]Repaid is defined as underpayments that have been paid back to the provider. MSP RACs were not tasked with identifying under-payments.
Note: For this Evaluation Report, CMS lists all dollars actually collected and repaid between March 2005 and March 2008. In contrast, reporting for the FY 2006 RAC Status Document was based on overpayment and underpayment *notification letters* that were sent to providers and to the Medicare claims processing contractor during the fiscal year.
Source: For Claim RACs, RAC invoice files and RAC Data Warehouse. For MSP RACs, Treasury deposit slips.

Source: CMS. "The Medicare Recovery Audit Contractor (RAC) program: An evaluation of the 3-year demonstration." (2008).

Accessed July 23, 2011. www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf.

To maximize transparency of the program and keep providers up-to-date, CMS suggests that providers visit the website of their assigned RAC to find this information.[10] Because many providers have found that the RACs' websites can be difficult to navigate, some consulting firms (including ours) have created websites that allow providers to access, sort, filter, and download issues. This can be especially helpful for physician practices that do not want to scroll through hundreds of issues that apply only to hospitals or other providers in order to find those issues that affect their practices. However you access the information, stay updated on the RAC target issues and major findings and adjust your expected risk of recoupments as new issues are added or modified. We discuss assessing your risk of recoupments in Chapter 2.

All indications point to CMS moving to a bundled payment system that will follow a patient's episode of care and will allow for payment recoupment across all providers. For instance, if a Part A inpatient Medicare severity diagnosis-related group (MS-DRG) is denied, other providers, the physician's Part B payment for example, may be denied as well. And, in the same episode of care, if a postacute stay was required, the postacute stay may be also be denied. For this reason, physicians should review not only issues specifically labeled provider-type physician, but also Part A issues they may be associated with either due to the type of patients typically admitted for hospital care or by nature of their specialty. Physicians should also review issues for outpatient hospitals, ambulatory surgery centers, etc., related to any procedure they perform in their office or elsewhere.

> We also encourage physicians to work with affiliated facilities and ask to be immediately notified when an associated case is under review by the RAC.

Unfortunately, keeping abreast of all RAC issues for your region is not as easy as going to an issues website and pulling out the newly posted issues. Existing issues can be changed at any time with no notification. Changes to previously posted audits include added MS-DRGs reviewed, changes in the list of states affected, links to additional information, and removal of medically necessary exclusions for specific MS-DRGs.

Although we do not address specific vulnerability issues in this book (except as part of case studies), we provide you with the tools you need (in the form of structure, process, and people) to mitigate your risk by

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10. Although CMS has provided a RAC e-mail address *(RAC@cms.hhs.gov)* on their recent update website (*www.cms.gov/Recovery-Audit-Program/Recent%20Updates.asp#TopOfPage*), when we emailed this address, we were asked to contact the RACs directly.

creating a more transparent, compliant organization. Within this framework, it will be the RAC committee or RAC coordinator (discussed in Chapter 3) that keeps track of approved issues and how these issues may be applied in an audit of your organization.

> Before reading further, you may want to take a moment to visit your RAC's website to familiarize yourself with the functionality of the website. Refer to the list on pp 5–6, and the region map on p. 7. For our database of RAC issues, visit *www.ractelligence.com*.

RAC audits are retrospective—the patient has been seen and discharged, the bill has been dropped, and (in most cases) paid before the RAC audit occurs. RACs are looking for cases where the documentation does not support the payment that was already made.

RACs are staffed similarly to fiscal intermediaries (FI) and Medicare administrative contractors (MAC) in that they employ nurses, certified coders, therapists, and a contractor medical director. You can request the credentials of the individuals that reviewed your documentation and made a claim of overpayment. The RACs are paid on a contingency fee basis, meaning they get a percentage of any improper payment (including underpayments); however, in an effort to ensure accuracy, the RACs must pay back the contingency fee if the provider appeal is won at any level. Each RAC has negotiated a different percentage of improper payments as their fee, as follows:

- Region A, DCS: 12.45%

- Region B, CGI: 12.50%

- Region C, Connolly, Inc.: 9.0%

- Region D, HealthDataInsights, Inc.: 9.49%

The RACs review paid claims using the same Medicare rules and policies used by FIs and MACs. Physicians must also structure their billing compliance programs on these same rules; however, the difficulty lies in the interpretation and application of the rules by each of the three parties: FI/MACs, RACs, and providers. Guidance on the rules can be gleaned from several sources such as the *Federal Register,* CMS manuals, national and local coverage decisions, CMS educational forums, and guidance from FIs or MACs. Because guidance can come from several sources, keep copies of all guidance used to create your billing compliance

policy or to determine validity of a specific claim or set of claims. If guidance is in the form of a website, save or print out the webpage because it may not be available online later. If the guidance is in the form of webinar, educational session, or phone call with CMS or an FI or MAC, keep notes detailing what was discussed. These documents and supporting notes can be submitted with an appeal as additional supporting documentation for a denied claim. Even with documentation of these source materials, however, there is no guarantee they will be effective.

A Quick Note About MACs

As required by the 2003 Medicare Modernization Act, all providers will transition from FIs and Medicare carrier contracts to MACs between 2005 and 2011. As with the RAC program, CMS has created MAC regions (termed *MAC Jurisdictions*) that will allow for Medicare A and B to fall under one contractor for providers in each region.[11] This may be step one in CMS' preparation for bundling of charges and accountable care organizations. As CMS broadens the RAC to Medicaid, Medicare Advantage, and Part D, it is logical to expect the MACs to align with RAC regions for all provider types.

There are different MAC jurisdictions for different types of providers (see **Figure 1.4**). The majority of providers (Part A and Part B) are covered by 15 different A/B MAC jurisdictions, but there are separate jurisdiction maps for other specialty providers. MACs for durable medical equipment (DME) suppliers cover the same four regions as the RACs. Home health and hospice MACs also have four jurisdictions, but they are not the same as the RACs. For more information on MACs, visit CMS' Medicare Contracting Reform website at *www.cms.gov/MedicareContractingReform/*.[12]

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11. Source: CMS. "Vision of future fee-for-service Medicare environment." (n.d.). Accessed July 23, 2011. *www.cms.gov/MedicareContractingReform/04_VisionofFuture FeeforServiceMedicareEnvironment.asp#TopOfPage.*

12. Source: CMS. "Overview." (n.d.). Accessed July 23, 2011. *www.cms.gov/MedicareContractingReform/01_Overview.asp#TopOfPage.*

| Figure 1.4 | A/B MAC Jurisdictions |

Durable Medical Equipment Medicare Administrative Contractor Jurisdictions
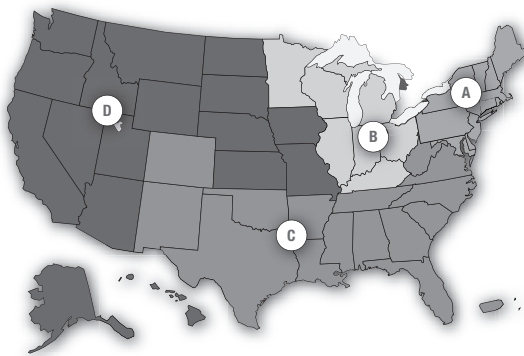
Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)
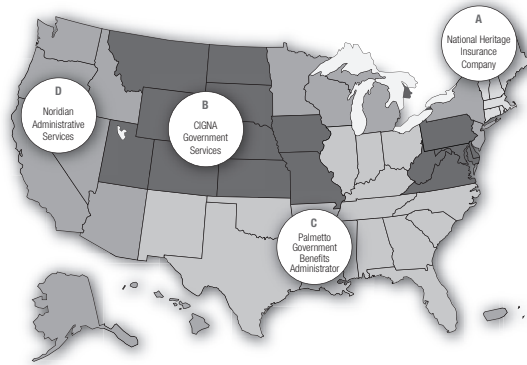
A/B MAC Jurisdictions
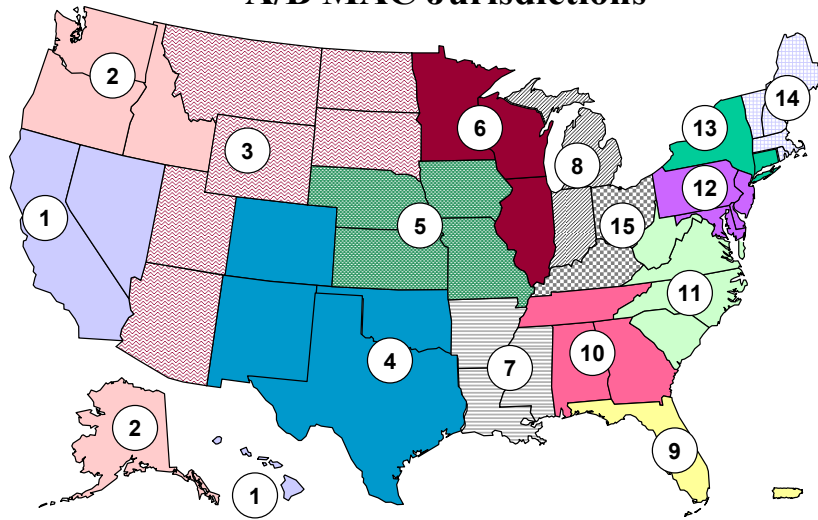
Source: CMS. "DME MAC jurisdiction map." (n.d.). Accessed November 27, 2010. www.cms.gov/MedicareContractingReform/Downloads/Specialty_MAC_Jurisdiction_MAP.pdf.

Source: CMS. "HH & H MAC jurisdiction map." (n.d.). Accessed November 27, 2010. www.cms.gov/MedicareContractingReform/Downloads/HHMACMAP.pdf.

Source: CMS. "A/B MAC jurisdiction map." (n.d.). Accessed November 27, 2010. www.cms.gov/MedicareContractingReform/Downloads/Primary_AB_MAC_Jurisdictions_MAP.pdf.

RAC Audits and Appeals Overview

RACs can perform three types of audits that can lead to a claim of improper payment: automated, semi-automated, and complex. As the names suggest, in an automated review, RACs use software to mine claims for errors; in complex reviews, RACs request to examine individual medical records. A semiautomated review is hybrid of the two, in which a suspicion of improper payment is found during an automated review, and RACs request additional documentation to make a determination. In semiautomated and complex reviews, you will receive a letter requesting specific documentation. For complex reviews, the letter is called an "additional documentation request (ADR)," and for semiautomated reviews, the term is "notification letter." By contrast, in an automated review, you will not know when and which cases are being reviewed. For each type of review, you will receive slightly different results documentation depending on the review type and the results:
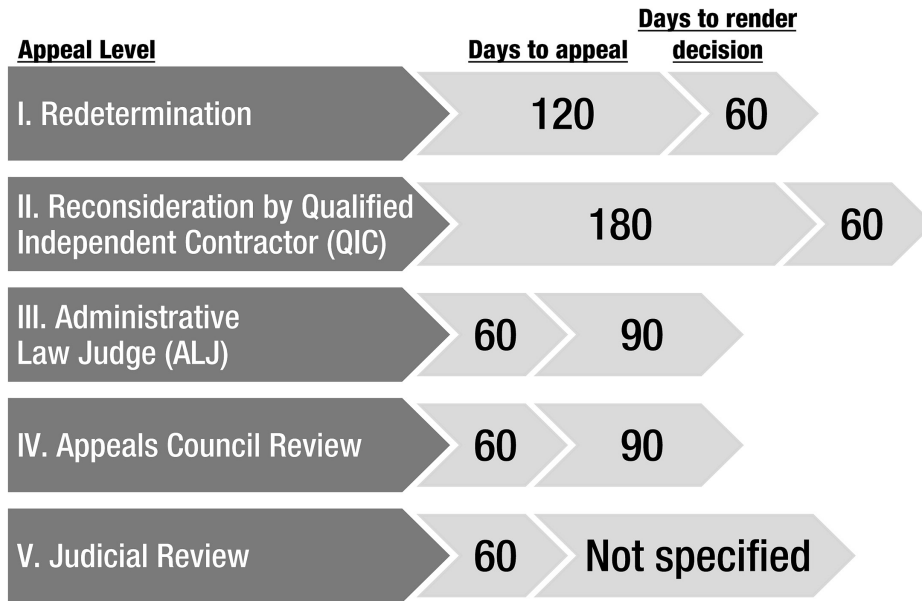
- In a complex audit, the RAC is required to send a review results letter outlining the findings of all claims reviewed, including those that show no overpayment or underpayments, and a demand letter if there is a claim of overpayment.

- In a semiautomated review, the provider will receive either a notice that there is no claim of improper payment or a demand letter.

- There is no results letter for an automated review, only a demand letter if there is a claim of overpayment.

With all review types, RACs may be able to use extrapolated error rates to calculate overpayments across multiple cases, and they may examine multiple claims from multiple providers for a single clinical episode. Each type of review is discussed further in Chapters 5 and 6, including a discussion on extrapolation and its potential impact to outpatient cases.

If an underpayment is found, the RAC will notify the FI or MAC who will then transfer the balance to the provider. If there is a claim of overpayment, it is the demand letter, not the results letter, that starts the clock on the rebuttal, discussion, recoupment, and appeals process. For each claim of overpayment, providers will need to decide whether to appeal and how far to take each appeal. There are five levels of appeal with a review by a separate body at each level. We discuss how to assess and navigate the appeals process in more detail in Chapter 7, but as an introduction, the appeals timeline and process is shown in **Figure 1.5.**

Figure 1.5 — RAC Appeal Timeline

Appeal Level	Days to appeal	Days to render decision
I. Redetermination	120	60
II. Reconsideration by Qualified Independent Contractor (QIC)	180	60
III. Administrative Law Judge (ALJ)	60	90
IV. Appeals Council Review	60	90
V. Judicial Review	60	Not specified

Source: Developed by Elizabeth E. Lamkin and Amanda W. Berglund.

During the first level of appeal (redetermination), there is a concurrent discussion period and a few milestones that occur after the receipt of the demand letter (Day 0):

1. Day 15: Deadline for the rebuttal statement in which the provider claims that recoupment should not take place because it will cause a financial hardship—the RAC may or may not continue with recoupment after review of the rebuttal statement.

2. Day 30: If an appeal is received by this deadline, then recoupment will not take place automatically on Day 41 (however, providers may want to make a payment on this day to avoid interest if an appeal is unsuccessful). For payments after this date, interest will be due and will be calculated from the day of receipt of the demand letter.

3. Day 40[13]: End of the discussion period, which allowed for discussion of the claim with the RAC medical director. New information may be submitted during this period, and it may or may not result in a reversal of the claim. It is not the formal appeal.

4. Day 41: Automatic recoupment takes place unless:

   - the appeal was received on Day 30

   - the discussion resulted in overturning of the denial

   - the rebuttal statement was successful in stopping recoupment until after appeals take place

5. Day 120: Appeal is due.

The RAC reviews requests for redetermination but a different individual conducts these reviews than the person who originally made the claim of overpayment. Each subsequent level of appeal is reviewed by a different body (see Figure 1.5) and, not surprisingly, costs increase for the provider with each level of appeal. However, documents, including additional justification for the claim, completed for a Level 1 appeal can be used for all levels of appeal—although different forms and documentation may be required as appropriate. After appealing at Level 1, there should be little additional cost through Level 3 unless testimony is required. Additional and significant costs may be incurred, however, at Levels 4 and 5, where outside resources like lawyers or consultants are needed.

After the second level of appeal, there may be timeline extensions if the reviewing body returns to the provider with a request for more information, or if other delays are granted to ensure due process. Although the facility may provide additional documentation at the early levels of the appeal, the first appeal letter submitted should be complete and stand on its own, even at the third level of appeal. Documentation in the chart cannot be changed; only additional notes or other documentation such as therapy notes can be submitted.

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13. In the case of the complex review, the discussion period actually starts with the receipt of the results letter rather than receipt of the demand letter, so if the demand letter is received one or more days later than the results letter, the discussion period is actually longer than 40 days.

Changes Based on the Demonstration Project

Based on the results of the demonstration project, the three-year trial review of RAC, CMS made several changes to improve the program, as shown in **Figure 1.6.** Many of these changes were made to reduce the burden on providers and to improve accountability and transparency of the RACs and their processes.

Figure 1.6	Changes From Demonstration Project	
Issue	**Demonstration RACs**	**Permanent RACs**
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	$10.00 aggregate claims	$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory
Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date - date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP included	Yes	No
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
RAC claim status Web page	Not Required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

Source: CMS. "The Medicare Recovery Audit Contractor (RAC) program: An evaluation of the 3-year demonstration." (2008). Accessed July 23, 2011. www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf.

One of the major changes was the discontinuation of the Medicare Secondary Payer (MSP) RAC program. In the demonstration project, the three MSP RACs (as opposed to the claim RACs) were tasked with identifying claims in which Medicare paid the primary portion of a claim while the beneficiary had insurance coverage with a carrier that should have been identified as the primary payer. As you may have noticed in Figure 1.2, the MSP RACs collected significantly fewer overpayments than the claim RACs who were charged with identifying improper payments. For this and other reasons, CMS decided to discontinue the MSP RAC program while allowing the claim RACs to identify MSP occurrences.[14] However, according to the CMS RAC Statement of Work, if a RAC finds a claim with an MSP occurrence that results in denial of the claim, the RAC does not get any credit (or compensation) for that denial.[15]

Another interesting change is that the RAC medical director must be available to discuss a claim during the discussion period. Considering the volume of audits and appeals, it will be interesting to see how the RACs will ensure that this occurs and that the discussions take place in a timely manner.

Track Your RAC Activity

After the demonstration project, the RACs were required to implement Web-based claim status tools for providers. The claim status webpages can be accessed through each RAC's main website and should allow providers to review what complex reviews are taking place, what documentation has been requested and received, when documentation is due to the RAC, and when responses are due by the RAC to the provider. Although you should use the claim status tool to ensure that the RAC has received the documentation you sent and to check on the progress of your claims, it is critical that you also track your RAC activity in your own tracking database. There are several software providers that will help you track each claim from audit through appeals so nothing falls through the cracks. The tracking software you use, whether home-grown, off-the-shelf, or specially developed for your organization, it should track documentation submission, remind you of submission and appeal deadlines, and allow you to assign issues and accountability for specific RAC-related tasks. Although tracking should start with the request letter for complex reviews, because it becomes most critical during the appeals process, we provide more information on tracking in Chapter 7.

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14. Source: CMS. "The Medicare Recovery Audit Contractor (RAC) program: An evaluation of the 3-year demonstration." (2008). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Downloads/RACEvaluationReport.pdf.*

15. Source: CMS. "Statement of work for the Recovery Audit Contractor program." (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Downloads/RACFinSOW.pdf.*

Stay Up-to-Date With Changes and Advice

Many of the changes instituted after the demonstration project stem from the difficulties experienced in managing the complex reviews, not just for the providers, but ultimately for the RAC auditors as well. We expect that as the RAC program is rolled out to more and more providers there will be further changes. Continue to visit CMS' RAC website (especially the "Recent Update" link) and the website of your region's RAC for updates to the program as well as additions to the issues list.

> Set a schedule for checking RAC websites and include reminders to do so in committee or individual calendars.

There are also several healthcare organizations that provide updated information, articles, and advice about CMS and the RAC program on their websites or through their newsletters, webinars, etc., such as HCPro, Inc.

CMS Update and Informational Links

Although we made every effort to provide valid links in this book, CMS and other organizations periodically update website navigation, rename links, or completely remove webpages and websites, thereby invalidating these links. If this happens, you may be able to find the information through the parent site—for CMS, this would be *www.cms.gov/recovery-audit-program/.* You are also welcome to contact us by clicking the "Contact Us" link on our website at *www.pacehcconsulting.com*, and we may be able to provide you with an updated link. Your RAC may also be able to help you with RAC updates. For specific questions, you can also e-mail CMS directly at *RAC@cms.hhs.gov.*

CMS has also made a multimedia effort to educate users on RAC with calls, e-mails, videos, and slideshows:

- Time and call-in information for Informational "RAC 101" calls are posted on the CMS RAC website.

- Educational slideshows—the spring 2010 RAC call can be accessed from the "Recent Update" section of the website under downloads. Click "Slide Presentation for RAC 101 Calls." There is a very similar

slide presentation on the overview section of the website, but as of the writing of this book, the one on the "Recent Update" site is more current.[16]

- You can sign up for e-mail updates by clicking the "Get Recovery Audit Contractor (RAC) E-mail Updates" link on the RAC update page.

- CMS and U.S. Department of Health and Human Services (DHHS) have a channel on YouTube where they post educational videos and their sponsored commercials. The RAC 101 Educational Video Presentation can be found at *www.youtube.com/watch?v=IHFXsfP99Bc*.[17]

Links to Your Regional RAC

You should regularly check your RAC's website for updates and changes (see pp 7-9). If you have any questions, use the e-mail address provided to contact your RAC and keep copies of all correspondence, including notes of phone calls and webinars.

16. Source: CMS. "Recovery Audit Contractors (RACs) and Medicare." (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Downloads/RACODFslides. pdf*; CMS. "Recovery Audit Contractors (RACs) and Medicare: The who, what, when, where, how and why?" (n.d.). Accessed July 23, 2011. *www.cms.gov/Recovery-Audit-Program/Downloads/RACSlides.pdf/.*

17. Source: CMS and DHHS. "Recovery Audit Contractor Program Overview (RAC 101)." (n.d.). Accessed November 27, 2010. *www.youtube.com/watch?v=IHFXsfP99Bc.*

The RAC Toolkit for Physician Practices

ELIZABETH E. LAMKIN, MHA ● AMANDA W. BERGLUND, MS, MBA

The RAC Toolkit for Physician Practices: *Protecting Your Bottom Line Under Medicare's Recovery Audit Contractor Program* is your practice's answer to turning plans into proactive action for RAC success.

Authors Elizabeth E. Lamkin, MHA, and Amanda W. Berglund, MS, MBA, describe how to establish and sustain an effective RAC-preparedness structure that can be adapted to fit any organization's system. They provide best practices for successful processes and outline each staff member's role in your RAC audit program.

Physician practice settings are getting audited by RACs. Whether you're dealing with a RAC or another government auditor, you need a program that's running as effectively as it can be. You will use the authors' tested, proven, and practical tools to build a more effective billing compliance program. You'll learn how to bring finance, business office, and clinical groups together for operational improvements that drop right to the bottom line.

The RAC Toolkit for Physician Practices will show you how to:

– Take a systemic approach to RAC compliance

– Incorporate effective structure and processes into existing systems for measurable results

– Organize committees and facilitate information flow

– Appeal effectively and within deadlines

– Use proven tools and methods for an effective RAC program

RACTP

HCPro