CMS makes big changes to RAC program

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On December 30, 2014, the Centers for Medicare & Medicaid Services (CMS) announced a number of changes to the Recovery Audit Contractor (RAC) Program in order to sharpen agency oversight, reduce the burden on providers, and increase transparency. The changes include the following:

1. Portal Design. CMS will work with auditors to enhance each Recovery Auditor's provider portal with a focus on "including more uniformity and consistency in the claim status section."
2. Look-Back Period. CMS will now restrict the Recovery Audit Contractor (RAC) program's look-back period to six months from the date of service for patient status reviews. However, hospitals must submit an inpatient claim within three months of the date of service for this look-back restriction to take effect.
3. Audit Timeframes. Recovery Auditors will now have only 30 days, instead of 60 days, to complete complex reviews and notify providers of their findings. This change was made to provide more immediate feedback to the provider on the outcome of their reviews.
4. Discussion Period. Recovery Auditors must now wait 30 days after their determination before sending the claim's adjustment request to the MAC for recoupment. This additional time allows a provider to request a discussion with the contractor prior to the review by the MAC. The Recovery Auditors must confirm receipt of a provider's discussion request or other written correspondence within three business days.
5. Volume of Reviews. Recovery Auditors will be required to broaden their review topics to include all claim types (e.g. inpatient, outpatient, etc.) to avoid focusing too much of their resources on inpatient hospital claims. The updated plan also adjusts the level of review based on a provider's denial rates: providers with lower denial rates will have lower levels

of review, and rates will be adjusted as a provider's denial rate declines.

6. Performance Standards. Recovery Auditors will be required to maintain an overturn rate of less than 10 percent at the first level of appeal, excluding claims denied due to "no or insufficient documentation or claims that were corrected during the appeal process." Recovery Auditors who fail to meet the performance standards will be placed on a corrective action plan.
7. Contingency Fee. Recovery Auditors now will not receive a contingency fee until after the second level of appeal is exhausted. This delay in payment helps assure providers that the decision made by the Recovery Auditor was correct based on Medicare statutes, coverage determinations, regulations and manuals.

These improvements will be effective with each new contract awarded under the program, beginning with the Region 5 contract for identifying improper payments to home health, hospice and medical device suppliers, which was awarded to Connolly LLC in December 2014. CMS had previously announced that Region 3 contract would be finalized by the end of 2014, but a new contractor has not yet been announced. Contracts for Regions 1, 2 and 4 remain under a "pre-award protest" and are unlikely to be awarded until late summer 2015.

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