Ref	Audit Description	Pre Pay	Post Pay
RAC-A	Recover Audit Contractor/Automated Review		**X**
RAC-C	Recovery Audit Contractor/Complex Review		**X**
CERT	Comprehensive Error Rate Testing		**X**
DME MAC	Regional DMEPOS Claims Processing Contractor	**X**	
Z-PIC	Zone Program Integrity Contractor	**X**	**X**
OIG	Office of the Inspector General	**X**	**X**

Definitions

Post-payment

- ✓ Audits or reviews look back at already-paid claims to ensure that all coverage criteria and other claim requirements in effect at the time of payment were met.

Prepayment

- ✓ Audits or reviews look at claims that have been submitted to ensure all coverage criteria and other claim requirements have been met before the claim is initially processed and paid.

RAC (Recovery Audit Contractor)

RAC-Automated Review:

- Randomly selected claims are screened against computerized systems edits that have been built to determine if coverage (e.g., diagnosis codes) and claims (e.g., modifiers) requirements are met.
- Claims that do not pass the computer edits are considered overpaid.

RAC-Complex Review:

- Claims are randomly chosen for complex review
- RAC sends the provider or supplier an Additional Documentation Request (ADR) requesting clinical and administrative documentation for the services billed.
- Claims are review by RAC staff to determine if medical necessity and claim fling requirements were met.
- Claims or services that are determined not to meet requirements are considered overpaid.

- ✓ CMS contracts with private companies to administer the RAC program and to conduct audits of previously paid Medicare claims.

- ✓ Contractors are paid a percentage of every dollar (up to 12.5%) in overpayments collected.

- ✓ RAC program is to "focus on companies…whose billings for Medicare services are higher than the majority of other providers and suppliers in the community."

- ✓ Almost any issue or inconsistency found in a claim or medical record provides enough justification for the RAC to demand recovery of claim payments made by Medicare.

- ✓ The RACs can look back up to three years ***from the date of claim payment*** to review claims.

- ✓ The RACs are required to utilize the claims requirements and coverage guidelines that were in place on the date a service was provided.

- ✓ Timelines for submission of documentation (Complex reviews) and instructions for appealing (Automated reviews) are outlined within the initial correspondence received from the RAC.

CERT (Comprehensive Error Rate Testing)

- ✓ Purpose is to insure that the contractors who process Medicare claims are doing so accurately and within the guidelines set by Federal law, CMS regulation, and the DME MACs' own Local Coverage Determinations (LCDs.)

- ✓ The CERTs review a relatively small, random sampling of claims processed by each DME MAC.

- ✓ CERT contractors are not paid on a contingency basis; they receive a set amount to fulfill their contract with CMS and are not incentivized to recoup overpayments.

- ✓ CERT audit requests are clearly identified as such; the CERT contractor will often make a courtesy call to confirm that the audit request was properly received at the PCC.

- ✓ Timelines for submission of documentation are outlined within the RAC audit request.

DME MAC (Regional DMEPOS Claims Processing Contactors)

- ✓ DME MACs may initiate pre-payment reviews or audits based on:
  - The code(s) or type of item or service billed;
  - The provider or supplier of the item or service; or
  - A combination of both.

- ✓ DME MACs may identify individual providers or suppliers for pre-payment review or audit based on:
  - Initial enrollment with Medicare, as an extra safeguard until a track record of valid claim submission is established;
  - Complaints received by the DME MAC;
  - Statistically aberrant billing practices; or
  - Other indicators of potential fraud or abuse.

- ✓ Specific codes or services may be identified for pre-payment review or audit by the DME MACs when:
  - There is an increase in utilization and billings over previous time periods; or
  - When concerns of wider-spread erroneous, abusive or fraudulent billing are identified.

Z-PIC (Zone Program Integrity Contractor)

- ✓ CMS contracts with private companies to administer the Z-PIC to initiate pre- and post-payment audits in geographic areas where Medicare has reason to believe that claims are potentially non-compliant.

- ✓ May also initiate pre- and post-payment audits for individual providers or suppliers where fraud, abuse, and/or other non-compliance is suspected.

OIG (Office of the Inspector General)

- ✓ OIG initiates both pre- and post-payment audits of claims for specific providers and suppliers where there is reason or evidence to determine that claims are potentially non-compliant, or claims filing practices are fraudulent or abusive.

Tips and Hints

Separate File for Each RAC

- Create a file folder for each RAC audit for each patient.
- This folder should contain
    - All the paperwork you received from Medicare and the RAC
    - Copy of the forms you send Medicare.
    - Copy of all the patient file documentation you send to Medicare.
- Yes, this file will have a duplicate of many documents that are in the patients master file, however, by having this one separate file for each RAC, it is beneficial to provide:
    - Visibility to each RAC to prevent things "slipping through the cracks"
    - Access to the pertinent information related to the RAC to provide easy reference to what you received and what has been sent.
    - Keeps the information and forms in chronological order.
    - If it goes to an ALJ, you have an accurate record of exactly what has been sent to appeal this case.

Create a one page Chronology Page for Each RAC

- In each RAC file maintain a one page form to write in the important dates and actions of basic information for each level the process (sample templates available)

Appeal the Specific Denial Language

- The appeal must address and focus specifically on the reason for denial.
    - Example, if the denial is "lack of medical necessity"
        a) DO confirm that you met Medicare Medical Necessity Standards.
        b) DO NOT attempt to explain why you decided the hydraulic knee was the correct choice of knee, this has nothing to do with the case, it is based upon Medical Necessity, it is NOT based upon your personal opinion as to which knee you believe is most appropriate.
    - Example, if the denial is based upon "lack of physician notes"
        a) DO confirm that Medicare policy requires Medical Records, which include documentation from physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports."
        b) DO NOT attempt to explain why the doctor did not provide any notes, or that the doctor is not supposed to keep notes about the prosthesis, this is not relevant to the case, physician notes are NOT required, what is required is documentation in the Medical Record, which includes your clinic notes.

Meet Every Deadline

- The number one reason for denials being upheld is that the provider did not respond timely, you are required to meet the deadline, you miss a deadline, you lose.

Read the Medicare Policy

- Denials can be based upon a Medicare bulletin or memo that in reality can be a misinterpretation or contradiction of the published Medicare Policy
- If a denial refers to or quotes any Medicare bulletin or memo, reference the Medicare policy or LCD to determine if the reason for denial is accurate and a correct interpretation of the written policy.