A Look Within the Recovery Audit Review Process

Recovery Auditors have returned nearly $10 billion to the Medicare Trust Fund while reviewing no more than 0.5% of any provider's claims. They employ numerous staff from the medical field to assess claims – Medical Directors, Nurses, Coders and countless healthcare reimbursement experts. All three types of review are overseen by the auditor's Medical Director. Following is a diagram that walks through the process that takes place inside a Recovery Audit company.

1 CLAIM RECEIVED

Claims data is received from CMS.
Loaded into auditor's data mining software.

2 CLAIM DATA PROCESSED

Complex algorithms run on the claim data to identify potential improper payments among CMS approved issue parameters and ensuring proper use of CMS guidelines, policies, coding, etc.

3 REVIEW PROCESS

Complex Review

- Request & obtain medical record
- Nurses & coders review medical records for improper payment determinations

Semi-Automated Review

- Letters are sent to providers notifying that they have the option to submit additional information
- Nurses & coders review documentation for improper payment determinations

Automated Review

- Healthcare reimbursement experts manually validate
- Claims with errors are sent to the MAC

4 NO FINDING OR FINDING

NO FINDING

- ✓ Claim re-reviewed* by nurses and coders to verify non-finding
- ✓ Generate non-recovery letter and mail to provider
- ✓ Update status in Recovery Audit Data Warehouse
- ✓ If provider wishes to discuss the claim for potential underpayment, before being sent to the MAC, the claim is then held for discussion

**Re-reviews are conducted on a random sample of claims*

FINDING

- ✓ Enter improper payment rationale in Recovery Audit Data Warehouse
- ✓ Re-review* conducted by nurse and coders for quality and to confirm finding
- ✓ Software is used to re-price the claim and generate savings/underpayment, claim is then sent to the MAC for adjustment
- ✓ Submit new information to Recovery Audit Data Warehouse
- ✓ Data Warehouse reconfirms eligible claim
- ✓ Send Review Result Letter to provider
- ✓ If provider wishes to discuss the claim before being sent to the MAC, the claim is held for discussion

Claim is closed

When a chart is requested, an informational letter is issued or automated finding submitted to the MAC. The claim then appears in the RAC's Provider Portal website and is updated as its status changes. Providers can track the claim through the process.

5 THERE ARE 3 POTENTIAL OUTCOMES FROM THE DISCUSSION PERIOD

The discussion period allows providers the opportunity to speak with their Recovery Auditor about their claim, correct any mistakes and provide rationale or clarification regarding the way the claim was billed. As a result, claim determinations can be overturned by the RAC and moved from "finding" to "no finding" during this period. Alternatively, the finding decision can also be upheld as an improper payment, at which time a provider either repays the payment received for that service or may file an appeal through the five-level appeals process.

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