Medicare RAC Prepayment Audits Are Fast, Efficient and Effectively Recover Program Improper Payments

The Centers for Medicare & Medicaid Services (CMS) has been working to implement programs that would move Medicare away from the "pay and chase" model of recovering improper payments. Despite numerous urgings of the Government Accountability Office (GAO), the agency has not sought the legislative authority to permanently implement the Medicare Recovery Audit Contractor (RAC) Prepayment Review program, which has been tested and proven successful in identifying improper payments prior to paying claims without any burden on providers.

In September 2012, CMS began allowing RACs to review a small subset of claims before they were paid as part of a Demonstration Project. Claim reviews were completed quickly and efficiently to ensure providers had complied with Medicare coverage and billing rules – within 30 days of receipt – ensuring prompt and correct payment to providers.

During the demonstration, RACs reviewed short-stay inpatient hospital claims and certain MS-DRGs selected for review based on Comprehensive Error Rate Testing (CERT) data. Outpatient therapy claims were added to the scope of work beginning in April, 2016 to comply with the requirements of the American Taxpayer Relief Act (ATRA) of 2012.

The prepayment review demonstration took place in just 11-states, during which time RACs prevented $192.8 million in improper payments from leaving the program.

The demonstration was planned as a three-year program, however, it was paused by CMS before the two-year mark and never restarted. The project remained on hold until its conclusion in August 2015. Due to the hold, there were no claims reviewed as part of the demonstration in FY 2015.

Pre-payment reviews are often confused with pre-authorization reviews. They are not the same:

Prepayment Review	*Prior Authorization Review*
Review of claims before they are paid to ensure the provider complied with Medicare Payment Rules	Prior Authorization is required before services are rendered to the beneficiary or it will be denied when billed to Medicare. Assures that all relevant coverage, coding and clinical documentation requirements are met before the item is furnished to the beneficiary and the claim is submitted for payment.
CMS defines services which will be reviewed.	CMS defines services which require prior authorization.
Primarily focuses on issues/services with a high Comprehensive Error Rate Testing (CERT) error rate	Primarily focuses on medical service/equipment which are subject to unnecessary utilization.
Reviewed by Recovery Auditors	Reviewed by Medicare Administrative Contractors
Prevents pay and chase - Avoids the need for Medicare to pursue the provider for services already paid. Allows the provider to make claim corrections within the timely filing limits.	May potentially delay the provider's ability to provide immediate patient care.
Decision rendered within 30 calendar days of receipt of medical records.	Initial Request: 10 business days Subsequent Request: 20 business days Expedited Request: 2 business days
Eligible for Standard Appeal Process	Eligible for Standard Appeal Process

The GAO Urges Implementation of Medicare RAC Prepayment Reviews

For the past two years, the GAO has consistently urged CMS to ask for the legislative authority to implement a permanent Medicare prepayment review program to prevent improper payments from leaving the program in the first place.

To date, CMS has thus far declined to implement prepayment reviews. **The Council for Medicare Integrity asks Congress to provide CMS with the legislative authority to move forward with implementation of a permanent Medicare RAC Prepayment Review Program.**

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Claims Are Reviewed Quickly Within a Prepayment System

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A claim is flagged for review per CMS defined selection criteria.

Claim selection files are transmitted to the RAC from the CMS Enterprise Data Center.

Daily

For tracking purposes RAC uploads claim and subsequent review statuses to RAC Data Warehouse as claim moves through review life cycle.

Daily

RAC issues ADR letter to the provider.

Within 3 days from receipt of the File from the Data Center

Provider sends medical records for the claim to the RAC. If records are not received within 50 days, the MAC will issue a technical denial.

Medical record for that claim is loaded into the RAC system when received.

Daily

RAC lets Medicare Administrative Contractor (MAC) know the medical records have been received.

Daily

RAC reviews the medical record and claim against Medicare coverage and billing rules.

Claims are reviewed within 30 days of receipt of medical records.

If the claim is **approved** – the MAC then officially releases the claim for payment.

If the claim is **denied** – the MAC officially denies the claim and the provider can make adjustments and refile or choose to appeal to the MAC level (level 1) of the Medicare appeals process.

Claims are denied or paid within 5 days of receipt of the RAC Review outcome

Audit review findings and rationale are sent to both the provider via a review results letter and to the MAC.

Review results are communicated to MAC within 24 hours of release of review results letters to providers

Lessons Learned from the Prepayment Demonstration

- **Recovery Auditors should select the claims to be reviewed using their very effective analytics programs.**
- **Fast access to claim files allows RACs to review claims more quickly.**
- **Letters to providers should clearly specify which contractor sent the letter and where the requested medical records and supporting documentation should be sent for review.**

Learn more at medicareintegrity.org