COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:	**RECOVERY AUDIT CONTRACTOR PROGRAM**		
Category:	9 - Leadership	**Policy No.:**	947
Originally Issued:	9/10/2010	**Update (U)/Revised (R):**	3/26/2019
Distribution:	**Hospital-Wide** ☒	**If not Hospital-Wide, Other:**	

PURPOSE:

To establish a process for management and tracking of RAC Audits.

DEFINITION(S):

RAC Program: RAC is a federal program designed to identify and correct Medicare and Medicaid improper payments through the detection and collection of overpayments made on claims for health services provided to Medicare and Medicaid beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement actions that will prevent future improper payments.

Automated Review: A claim review conducted using only claims data analysis to identify improper payments.

Semi-Automated Review: Similar to automated, these reviews are initiated with dta analysis; however, the facility/provider may submit supporting documentation to support the claim.

Complex Review: A claim review which utilizes a complete review of the supporting medical records to determine whether there was an improper payment. The reviewer must be a qualified health care coder or clinician on the type of review being conducted.

POLICY:

Olive View-UCLA Medical Center shall ensure compliance with all requests for medical records, evaluation of denials, and timely submission of appeals related to the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) Program.

PROCEDURE:

I. Establishment of RAC Response Team

Olive View-UCLA Medical Center shall establish a RAC Response Team that shall include the following members:

- Compliance Officer (RAC Coordinator)
- Chief Financial Officer (Back-up RAC Coordinator)
- Risk Management Representative

- Patient Accounts Representative
- Utilization Management (UM) Representative
- Medical Administration Representative
- Health Information Management (HIM)/Coding Representative

The Team may include additional members as required.

II. Responsibilities of RAC Team

The Team will establish a regular meeting schedule and plan to prepare for RAC audits. The Team will:

A. Evaluate all new issues approved by CMS and released by RAC Contractors for audits.

B. Conduct internal audits, in concert with the DHS Audit and Compliance Division, as appropriate, to identify potential areas of vulnerability.

C. Identify and correct any areas of payment errors.

D. Identify resources necessary for management of the RAC process.

E. Develop corrective actions, as appropriate, to address weaknesses or problems identified through the internal review.

F. Monitor and track RAC requests.

G. Monitor results of RAC reviews, as well as findings from other similar audits, to identify trends and develop appropriate corrective actions.

III. Tracking and Management of RAC Requests

A. Coordination of processing and tracking of RAC record requests will be processed through the Compliance Officer and/or Risk Management Office.

B. Upon receipt of a request from the RAC for supporting documentation, the Compliance Officer, or designee, will review the request, create a RAC tracking document and notify the Risk Manager and the HIM Director.

C. The request will be distributed to the RAC Team for the following actions:
   1. HIM will compile the requested information and will:
      a. Number the requested pages from the medical record
      b. Ensure that both electronic and paper components of the medical records related to the request are identified and incorporated into the complete medical record.
      c. Scan and load the completed medical record documentation to the RAC Shared Drive.

2. Patient Accounts will pull all claims information and provide the amount of each requested claim.
3. Utilization Management/Compliance Officer will review all claims for medical necessity and document such on the RAC tracking document.

D. Prior to submission of the requested information, the Compliance Officer will coordinate a pre-audit to be conducted by RAC Team members, as appropriate. RAC Team members will have five (5) business days to review the documentation, upon completion of their review they will provide comments to the Compliance Officer as to issues or problems that may exist in the requested information.

E. Once the RAC Team review is complete, the Compliance Officer, or designee, is responsible for:
1. Confirming the submission instructions, submitting the requested information and obtaining confirmation of receipt from the RAC; and
2. Documenting in the tracking system the date on which the documents were sent to and received by the RAC.

F. Any extension requests will be processed through the Compliance Officer.

G. Upon receipt of a Remittance Advice with the code N432 ("Adjustment based on a Recovery Audit") from the Medicare Administrative Contractor, the Compliance Officer will be determined whether the repayment was for an automated, semi-automated or complex review. If it was a complex review, the Compliance Officer and UM Physician Advisor will review within ten (10) calendar days to determine whether an appeal is warranted and will follow the steps outline below in Section IV.

IV. Appealing a RAC Finding

A. If the hospital believes an appeal of a RAC finding is warranted, the Compliance Officer will consult with the UM Physician Advisor to review the medical record, RAC findings, and justification for the review.

B. Upon the determination that an appeal is appropriate, the Compliance Officer, or designee, will submit an appeal letter to the RAC, within the required timeframe, using the required appeal forms.

V. RAC Response Timeframes

A. Olive View-UCLA Medical Center has 45 days to the RAC's request for documentation. If the information is not provided timely, the RAC may declare a technical denial for which there are no appeal rights. The RAC has up to 30 days to conduct its record review and issue either a No Findings Letter (which confirms the review is complete and there were no findings) or a Review Results Letter which confirms the review is complete and there was an overpayment or underpayment finding.

B. Upon receipt of a Review Results Letter, Olive View-UCLA Medical Center has 30 days to submit a Discussion Request to rebut the findings. The RAC has 30 days from the date of receipt to provide a detailed, written rationale with their determination.

C. Olive View-UCLA Medical Center may submit a First Level of Appeal within 120 days from the date of receipt of the Remittance Advice (RA) that lists the initial determination. The review of the appeal consists of a review of the initial claim determination and will be conducted by the Medicare Administrative Contractor (MAC), which has 60 days to conduct its review of the appeal. The MAC decision will be received via a Medicare Redetermination Notice (MRN) or if the initial decision is reversed and the claim is paid in full, in the form of a revised RA.

D. A Second Level of Appeal may be filed within 180 days of the receipt of the MRN or RA. The Medicare Qualified Independent Contractor (QIC) has 60 days to conduct a review of the 2nd Level Appeal.

E. A Third Level of Appeal may be filed for hearing by an Administrative Law Judge (ALJ), within 60 days of receipt of the QIC decision on the Second Level Appeal or after expiration of the applicable QIC reconsideration timeframe if no decision is received from the QIC. The ALJ has 90 days to conduct the review at this level. The review may be an on-the-record review or an interactive hearing.

F. Within 60 days of receipt of the ALJ's opinion or after expiration of the applicable ALJ hearing timeframe, the hospital may submit a Fourth Level of Appeal to the Medicare Appeals Council. If appealing the ALJ decision, the Medicare Appeals Council has 90 days to conduct a document review the appeal and render a decision. If appealing after expiration of the applicable ALJ timeframe, the Medicare Appeals Council has 180 to conduct the review.

G. If the Fourth Level of Appeal is deemed unfavorable, a request for review by the U.S. District Court must be filed within 60 days of the Fourth Level Determination or after expiration of the applicable Appeals Council review timeframe.

VI. Corrective Action/Quality Improvement

Findings from the RAC Audit will be utilized to evaluate and improve processes, such as compliance with medical necessity, documentation, coding, and charging.

ATTACHMENTS/FORMS:

None

REFERENCE(S)/AUTHORITY:

Tax Relief and Health Care Act of 2006, Section 302
CFR, Title 42, Chapter IV, Subchapter B, Part 405, Subpart I

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