Recovery audits
Practical update for neurology practices

Joseph V. Fritz, PhD
Sandra Setlock, CPC
Daneen P. Grooms, MHSA

Summary
Recovery Audit Contractors (RACs) are contracted by the federal government to review providers’ medical billing. Experience has demonstrated substantial savings to the strapped Medicare fund, fueling increased scrutiny. RAC audits are constrained to published focus areas, and its targeted approach makes use of sophisticated analytics. Although some of the analyses used by the RACs may be proprietary, much of the auditing process is transparent, allowing providers to prepare their practices in advance of audits. This article reviews the current state of RAC auditing and offers strategies to minimize financial pain and leverage the process for competitive advantage.

Audits are performed by all payers, government or commercial, to ensure that only appropriate medical services are being rendered and billed appropriately. The concept is simple, but execution can be daunting given the preponderance of process regulations, multiplicity of auditing agencies, and obscure acronyms. Table 1 lists common acronyms, appendix 1 lists definitions, and appendix 2 lists agencies.

Some audits are conducted automatically, based on computer analysis of claims data; some are conducted by auditors who review medical charts. A variety of statistics are used to target claim types based on historic utilization trends or common errors, such as those cataloged by the Comprehensive Error Rate Testing (CERT) program.

Automatic audits may be triggered when certain incompatible Current Procedural Terminology (CPT) codes are billed on the same day. For example, Medicare Administrative Contractors (MACs) use a database called Medically Unlikely Edits (MUEs) developed through the National Correct Coding Initiative (NCCI) to detect CPT codes that should not normally be billed together. Audits are also triggered when a provider’s accumulated claims statistics indicate a higher than normal frequency of a particular code. For example, Medicare statistics are readily available that show the typical distribution of Level 1 through 5 Evaluation & Management (E/M) CPT codes for neurologists. Providers that statistically appear to “upcode” are flagged for further scrutiny (i.e., “complex audits” that rely on chart reviews).

Dent Neurologic Institute (JVF, SS), Buffalo, NY; and Regulatory Affairs (DPG), American Academy of Neurology, Minneapolis, MN.

Correspondence to: dgrooms@aan.com
Automated RAC audits happen continuously, and can either preempt payment through denials, or recoup payments through reductions in future payments, or the practice can make installment arrangements.

In the case of complex audits, RAC auditors will physically request charts, but are constrained to a 45-day window within a 3-year look-back period and a maximum number of charts that is determined by the practice size (based on claims associated with the practice tax identification number). Gross or continuous errors uncovered by audits can create suspicion of misconduct, and result in more extensive auditing over a limitless period of time, with penalties ranging from fines to revocation of licenses and criminal prosecution.

**Current status**

All medical practices have likely been affected by auditing of some sort, whether through pre-authorization processes, claims denials, automated post-pay audits, or complex medical chart reviews. In 2012, 18.3% (50 respondents) of neurologists surveyed by the American Academy of Neurology (AAN) reported they had been audited in the prior 12 months, and of those audited, 44% had encountered a RAC audit. Disputing overpayment assessments requires prompt attention and can be a stressful, expensive chore. This may be why only 4.9% of Part B overpayment determinations were appealed in 2011. But it is important to realize that an appeal should be filed when a practice can demonstrate that errors were made. Indeed, 70% of the 2011 appeals to RAC audits resulted in a reversal.

Audits are driven by statistics; the likelihood of being audited increases if a practice is deemed an outlier compared to peers. Providers that bill Medicare are automatically part of the claims data analysis conducted by the CERT Center. These data are then used by a variety of agencies—including the Office of the Inspector General (OIG), regional MAC, and local RACs—to formulate annual strategic plans. Comparative Billing Reports (CBRs), generated under contract with the Centers for Medicare & Medicaid Services (CMS) by SafeGuard Services LLC, have increasingly been used to illustrate individual provider billing practices compared to population statistics. While the intent of the CBR is to be educational, this approach has also been used by private and government auditors to target complex audits.

It is unlikely that audits will decline. In fact, medical providers will be under increasing scrutiny as the highest levels of government invest significant resources in fighting inappropriate payments.

### Table 1  Acronym reference guide

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>ALJ</td>
<td>Administrative Law Judge</td>
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<td>CBR</td>
<td>Comparative Billing Reports</td>
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<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>DOJ</td>
<td>Department of Justice</td>
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<tr>
<td>DRG</td>
<td>Diagnostic-related group; inpatient issues related</td>
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<tr>
<td>FFS</td>
<td>Fee for service</td>
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<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
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<td>LCD</td>
<td>Local Coverage Determination</td>
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<tr>
<td>MUE</td>
<td>Medical Unlikely Edits: expected units per patient encounter</td>
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<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
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<td>NCCI</td>
<td>National Correct Coding Initiative: Column 1/Column 2 edits</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>RA</td>
<td>Remittance Advice</td>
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health care practices. In its Strategic Plan for Fiscal Years 2012–2016, the United States Department of Justice has identified 4 priority goals: 1) national security and counterterrorism; 2) violent crime and gang investigations; 3) health care fraud; and 4) protection of vulnerable people. The US Department of Health and Human Services’ OIG Work Plan defines specific target areas for new programs and investigatory initiatives. The 2012 Work Plan notes that as a result of focused efforts, there was a $16.7 return on each $1 invested in OIG’s health care oversight efforts. The OIG 2013 Work Plan notes that $5.2B will be recovered from fiscal year 2011, with an additional $4.6B still being pursued. Some OIG focus areas for 2013 that have a direct impact on neurologists include the following: high utilization of outpatient physical therapy services, high utilization of sleep testing procedures, questionable billing of electrodiagnostic testing, medical necessity of high-cost imaging studies, error rate for incident-to-services performed by nonphysicians, place-of-service coding errors, use of modifiers during the global surgery period, and beneficiary use of manufacturer copayment coupons.

Each of the 4 RACs publishes issues under review on its Web site (table e-1 at neurology.org/cp). For example, Performant Recovery (the RAC for Region A, formerly DCS) describes its audit issues at www.dcsrac.com/IssuesUnderReview.aspx. As of October 2012, some of the Region A issues include automated reviews for failure to correctly bill codes on the MUE list, NCCI denial for billing same provider/same date for Column 1 and Column 2 services, incorrect billing of CT scans, duplicate part B claims, procedures billed that were global to surgery, place of services coding errors, and incorrect bilateral billing. Connolly Inc., the RAC Contractor for Medicare Region C, announced that it will begin complex medical review of CPT code 99215 for a Level 5 office visit. Subsequently, CMS approved extrapolation of their findings based on a sampling of records. CMS later clarified that Connolly Inc. has been approved to perform an initial “test phase” review of CPT code 99215 claims of 3 physicians (who have already been notified) in Region C.

Preparing for audits
It is important to recognize that audits are part of ongoing government and payer initiatives to prevent health care overpayment and fraud. Survival begins by creating a practice that excels in efficiency and compliance, using audits to test and improve.

The first step in preparing for an audit is strategic: develop the proper infrastructure around corporate compliance as directed through a Corporate Compliance Plan. The Compliance Plan defines the process for conducting internal audits, monitoring, training, investigations, and responses to offenses. Commitment to compliance is best illustrated through appointment of a high-ranking compliance officer that is responsible for ensuring proper execution of the plan at all levels of the organization. Example Compliance Plans based on the OIG 2000 report are readily available on the Internet, and can be easily modified for individual practices. The most effective plans are actionable, acting as a binder for all policies and procedures, including a training plan that ensures all employees and providers receive regular education and feedback.

One of the Policies & Procedures documents referenced in the Compliance Plan should address preparation for recovery auditing. Since audits are time sensitive, processes and people should already be in place by the time an audit letter arrives. At least one person should be identified as the RAC team lead. This person should have a detailed understanding of the audit process, including current issues, timelines, and contact information. Periodic RAC team meetings should be held to review trends and processes. The RAC team is generally
composed of a team lead and a backup (who will be the point person upon receipt of a demand letter) along with billing and coding experts and representation from medical records. It is helpful to create a secure shared network folder to organize letters, responses, tracking spreadsheets, and reference materials. Reference materials include contact information for auditors, MAC representatives, templates for response letters, appeals and extension requests, links to Web resources, and scanned articles.

Upon receipt of a demand letter, your practice should follow a predefined checklist. An example checklist is shown in figure 1. Mailroom personnel must recognize letters from all potential auditors and immediately alert the RAC point person. The letter must be time stamped, critical deadlines must be transferred to calendars of key personnel, and specific requests must be summarized for the RAC team. Once the appropriate medical records are collated and reviewed with the provider, the RAC point person should request clarification from the RAC, if necessary, and also determine if an appeal should be considered. It can be useful to keep a copy of all documents transmitted to the RAC. You should also send the

Figure 1  RAC response checklist

A. Organize your RAC team
   - Senior leadership
   - Finance/revenue cycle management
   - Health information management
   - Corporate compliance
   - Business operations
   - Information technology
   - Clinical manager
   - Legal counsel

B. Compile and review medical records
   - Get perspective from key individuals
     - Rendering physician
     - Internal coding and compliance officer
   - Get clarification from RAC if necessary

C. Evaluate if an appeal is appropriate
   - Expert opinion (outside consultant, if necessary)
   - Legal counsel

D. Response/appeal process
   - Detailed cover letter jointly written by rendering provider and senior leadership (CEO)
   - Address letter as per Demand Letter to MAC
   - Provide appropriate supporting documentation (HIPAA compliant)
   - Maintain files on company shared drive
     - Scan and track everything
     - Develop spreadsheets, with patient names, information submitted

E. Mailing of responses and payments
   - Mailings:
     - Registered mail or certified mail only
     - Fed Ex does not deliver to a PO box
   - Payment Options:
     - Withhold future payments (via electronic remittance advice [ERA])
     - Payment plan related to hardship
     - One lump sum

CEO = chief executive officer; HIPAA = Health Insurance Portability and Accountability Act; MAC = Medicare Administrative Contractor; RAC = Recovery Audit Contractor.
required material by registered mail in advance of the deadline to ensure a timely response. If a deadline falls on a weekend or holiday, the documentation must arrive before the deadline. Figure 2 illustrates the deadlines for appealing RAC audits.

Learning from audits
Although audits can be intimidating, they provide an invaluable source of insight for practice improvement. Each coding or compliance error should be logged and reviewed with the provider. Individual and group trends should be identified for guiding educational programs.

Internal audits should be performed regularly. Software programs are available to help compare E/M coding levels compared to national statistics. Proactively reviewing a sample of charts with each service and provider can offer extremely effective and practical education. A simple approach is to have an experienced biller review just a few charts every day, continually cycling through each provider and documenting mistakes for provider feedback. A binary grade of 0 or 1 can be assigned per chart so that a running percentage of correctly coded reports can be easily calculated. If staff billing personnel do not have the time or expertise, consultants are readily available. Peer reviews can be done similarly to look for clinical decision-making, testing appropriateness, cloning, and other issues. When performing internal audits, be sure to use the same auditing tools and examination guidelines as your regional RAC. Specific providers who are consistent outliers must be identified, coached, and disciplined if necessary, with full support from physician leadership.

Leveraging the RAC process
In today’s economy, cost-effective and compliant practices are at a competitive advantage. The CMS Physician Value-Based Payment Modifier will increase or decrease reimbursement based on quality and cost metrics. Several payers have already implemented forms of
profiling that create preferred designations for physicians who pass quality and cost standards.\textsuperscript{7,8} The ability to align with an Accountable Care Organization will also become dependent on demonstrating cost-effectiveness.\textsuperscript{9} RAC audits and internal auditing processes can be extremely helpful for guiding practice improvements that are quite relevant and even marketable to payers and consumers.

**Cost to the practice**

Developing an effective compliance and auditing program requires an investment in time and personnel that includes billers, supervisors, medical records personnel, and consultants. Total costs associated with internal audits and actual RAC audits can add up to thousands of dollars per year.

For practices that employ their own billers, a systematic internal auditing process can be absorbed by experienced personnel at the cost of approximately 0.1 full-time equivalent (FTE). If an outside consultant is used, the price will vary depending on the desired analysis. For example, simple audits with limited feedback can be on the order of $4.25 per chart. More complex audits cost in the neighborhood of $37.50 per chart plus the cost of shipping, but provide more extensive feedback such as explaining medical decision-making level.

Consultant rates for RAC process or educational support average about $150 per hour. Large practices may allocate several FTEs to auditing and education. A single RAC audit can cost a practice approximately $8,000 in dedicated staff hours, plus legal and consultant fees in the event of large disputes or complicated situations.\textsuperscript{10}

The cost of recoupment can be much more substantial than the investment in compliance training and preparing for an audit. The worst-case scenario occurs if a practice develops a poor reputation for incorrect billing, incomplete or cloned documentation, or excessive utilization of services. If fraudulent activity is suspected, the game changes dramatically. Look-back periods become unrestricted, Medicare eligibility may be stripped, and the practice may become insolvent. Criminal penalties may also apply for the offending providers, and potentially for executives, who may be held liable for allowing illegal activities to persist.

**Ongoing advocacy efforts**

The AAN is committed to advocating on behalf of its membership by monitoring issues impacting neurology and sharing concerns with CMS, when appropriate. The Medicare section of the AAN Web site provides current news updates and information on CMS activities.

Together with several other medical societies, the AAN has asked the Office of Inspector General to review the effectiveness of the various Medicare contractors because problems have been noted. As a result of the high reversal rate when RAC demands are appealed, practice costs have increased, further burdening the strained health care environment. Overly aggressive audits are in part due to misaligned financial rewards in which RACs are paid on a contingent basis between 9% and 12.5% of recovered overpayments, with no penalties for incorrect assessments. Furthermore, the clinical qualifications of auditors have been called into question for the purpose of assessing medical decisions. Duplication of prior audits by Zone Program Integrity Contractor or Medicare Administrative Contractor audits has also been known to occur. Better coordination or even consolidation among all auditing bodies has been proposed to avoid excessive practice costs.

The AAN Web site provides information on RAC audits and how neurologists can perform internal billing audits to ensure appropriate payment and compliance.
Recently, the AAN\textsuperscript{11} and American Medical Association (AMA) have actively opposed the implementation of Level 5 audits on the grounds that the complexity of such cases does not lend itself easily to medical review, citing the history of low accuracy in Medicare RAC determinations. Concern has also been expressed that subspecialty data will not be properly represented, leading to excessive management costs for both CMS and providers.

**Resources**
The AAN Web site provides information on RAC audits and how neurologists can perform internal billing audits to ensure appropriate payment and compliance.\textsuperscript{12} The AAN and the AMA have jointly developed resources on their Web pages to help practices understand and respond to audits.\textsuperscript{13} Helpful information is also available from the following Web sites: AMA,\textsuperscript{14} Medical Group Management Association,\textsuperscript{15} and the American Academy of Professional Coders.\textsuperscript{16,17} A listserv through CMS delivers up-to-date information on a wide range of topics directly to your inbox.\textsuperscript{18} It is important to consult these resources regularly to remain current on recent developments.

**DISCUSSION**
RAC audits can be expensive and intimidating, but practices that embrace and aggressively act on the information garnered from the audit process can gain competitive advantages. Although auditors are motivated to find overpayment, they must operate within boundaries and erroneous decisions can be reversed. Preparation, training, and timeliness are critical to surviving and thriving in this era of increased scrutiny.

**APPENDIX 1**

**Definitions**

- **Automated review**: computer-generated data mining; Medicare coding and billing guidelines compliance issues, very little human oversight.
- **Complex review**: a medical record by a staff member is reviewed; chart documentation is requested and is needed to complete the review.
- **Contingency fee**: CMS pays RACs this percentage of recovered payments. Typically varies from 9\% to 12.5\%.
- **Compliance plan**: An effective Compliance Plan provides evidence that any mistakes were inadvertent, and this evidence would be considered in determining whether a medical practice or other health care entity has made reasonable efforts to avoid or detect misbehavior. An effective compliance plan should have 7 elements:
  - A clear commitment to compliance
  - Appointment of a trustworthy compliance officer with a high level of responsibility
  - Effective training and education programs
  - Auditing and monitoring
  - Staff communication and hotlines
  - Internal investigation and enforcement
  - Response to identified offenses and application of corrective action initiatives
- **Prospective audit**: an audit performed prior to the claim being submitted to the carrier for reimbursement.
- **Retrospective audit**: an audit performed after the billing process, after the claim has been submitted for reimbursement to the carrier.

**APPENDIX 2**

**Medicare contractors**

- **CERT**: Comprehensive Error Rate Testing Contractor: CERT randomly selects a sample of claims submitted to the MACs during each reporting period. They will request medical...
records from the health care providers that submitted the claims in the sample. When the medical records are submitted by the provider, they will review the claims in the sample and the associated medical records to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, assign errors to the claims.

**MAC:** Medicare Administrative Contractor: MACs serve as the primary point of contact for provider enrollment, Medicare coverage, and billing requirements. They also serve for training for providers, and the receipt, processing, and payment of Medicare fee-for-service claims for Medicare providers’ respective jurisdictions. Medicare providers will be assigned to the local designated MAC based on their geographic location to the MAC, which has jurisdiction for that benefit category and location.

**MIC:** Medicaid Integrity Contractor: Part of the Medicaid Integrity Program to investigate Medicaid fraud, waste, and abuse.

**RAC:** Recovery Auditors (Contractors): RACs identify underpayments and overpayments of claims paid under the Medicare program for services for which payment is made under Part A or B. This is accomplished through review of all claim and provider types and a review of claims/providers that have a high propensity for error based on the CERT program and other CMS analysis.

**SGS:** Safe Guard Services: The mission of the SGS is to help address fraud, waste, and abuse by performing Medicare data analysis and comprehensive problem identification and research to identify potentially fraudulent Medicare providers.

**ZPIC:** Zone Program Integrity Contractor: Agency set up into zones within the United States. These contractors have access to CMS National Claims History data, which can be used to look at the entire history of a patient’s treatment no matter where claims were processed. ZPICs look for billing patterns that make a particular provider stand out from the other providers in that community, enabling them to more readily identify overbilling and fraudulent claims.

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ACKNOWLEDGMENT
The authors thank members of the Medical Economics & Management Committee of the AAN for their review of the manuscript and comments.

STUDY FUNDING
No targeted funding reported.

DISCLOSURES
J. Fritz is a full-time employee of the Dent Neurologic Institute. S. Setlock is a full-time employee of the Dent Neurologic Institute. D. Grooms is a full-time employee of the AAN. Go to Neurology.org/cp for full disclosures.

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