

# Recovery Audit Contractor Program Underway

BY DENISE NAPOLI

WASHINGTON — Physicians and other providers in certain states are beginning to receive demand letters from Medicare Recovery Audit Contractors, Dr. Thomas Valuck said at a meeting of the Practicing Physicians Advisory Council.

Officials from the Centers for Medicare and Medicaid Services will begin to roll out the program to the rest of the country later this summer, with demand letters reaching providers in August or early September, according to Dr. Valuck, medical officer and senior adviser at the Center for Medicare Management.

The Recovery Audit Contractor (RAC) program is designed to identify and correct past improper Medicare payments, including underpayments. It began as a demonstration project in three states in 2005, and was made permanent and nationwide in 2006 by the Tax Relief and Healthcare Act. It is administered by private contractors who collect a fee based on the errors they detect.

The RACs—which have access to Medicare fee-for-service claims data—use software to analyze claims for inaccuracies regarding coding, billing, and payment. Beginning in September, the RACs will also conduct computer-facilitated “complex reviews” on diagnosis-related group (DRG) coding errors, according to Cmdr. Marie Casey, USPHS, CMS deputy director of recovery audit operations. And by 2010, the RACs will also review the medical necessity of certain claims, relying on the expert medical opinion of physicians and other medical professionals who work for the RACs.

Cmdr. Casey added that the RACs can audit any Medicare fee-for-service claims up to 3 years from the payment date, but for now will review only claims made on or after Oct. 1, 2007.

Cmdr. Casey and her colleague, Lt. Terrance Lew, USPHS, a health insurance specialist at the division of recovery audit operations at the CMS, offered advice for preparing for an RAC review:

► **Know where previous improper payments have been found so that you can avoid making the same mistakes.** This information is available at [www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC%20Evaluation%20Report.pdf).

► **“Keep a clean shop,”** Lt. Lew advised. “Make sure that you’re in compliance with all the applicable Medicare policies, coverage determinations, coding directives, requirements for documentation.”

► **Develop processes for tracking and responding to RAC requests and demand letters.** “There are timelines attached to demand letters,” Lt. Lew said. “You’re going to want to have a system for tracking those timelines, and knowing if you have X days to come up with a record for such-and-such a claim, or Y days to file an appeal, if that’s your decision.”

► **Appeal when necessary.** “If you make a business decision that an appeal is warranted, we would certainly encourage you to appeal,” Lt. Lew said.

► **Identify key RAC contacts.** Each region has its own RAC. (See box.)

Outreach designed to educate providers about the RAC program and what to expect is still being conducted in Regions B and D, and the CMS soon will begin outreach in Region A. The updated provider outreach schedule can be found at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac).

Provider outreach must occur in each state before an RAC is authorized to send any correspondence to a provider, such as a demand letter for recoupment or a request for additional documentation.

The RACs will begin with basic “black and white” reviews, Cmdr. Casey said, adding that these reviews will be per-

formed on an automated basis (no medical records are required). Starting in September, the RACs may begin reviewing coding issues and diagnosis-related group validations, which will require the review of additional documentation.

Once the RAC has been established in the region, the RAC may begin to review claims for medical necessity. The RACs may be contacted at:

► **Region A:** Diversified Collection

Services (DCS), 866-201-0580; [www.dcsrac.com](http://www.dcsrac.com).

► **Region B:** CGI, 877-316-7222; <http://racb.cgi.com>; [racb@cgi.com](mailto:racb@cgi.com).

► **Region C:** Connolly Consulting Inc., 866-360-2507; [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC); [RACinfo@connollyhealthcare.com](mailto:RACinfo@connollyhealthcare.com).

► **Region D:** HealthDataInsights Inc., 866-590-5598 (Part A); 866-376-2319 (Part B); [racinfo@emailhdi.com](mailto:racinfo@emailhdi.com). ■

## PLAVIX (clopidogrel bisulfate) tablet, film coated

clinical trials are listed below regardless of relationship to PLAVIX. In general, the incidence of these events was similar to that in patients receiving aspirin (in CAPRIE) or placebo + aspirin (in the other clinical trials).

**Body as a whole:** Allergic reaction, necrosis ischemic. **Cardiovascular disorders:** Edema generalized. **Gastrointestinal system disorders:** Peptic, gastric or duodenal ulcer, gastritis, gastric ulcer perforated, gastritis hemorrhagic, upper GI ulcer hemorrhagic. **Liver and Biliary system disorders:** Bilirubinemia, hepatitis infectious, liver fatty. **Platelet, bleeding and clotting disorders:** hemarthrosis, hematuria, hemoptysis, hemorrhage intracranial, hemorrhage retroperitoneal, hemorrhage of operative wound, ocular hemorrhage, pulmonary hemorrhage, purpura allergic, thrombocytopenia. **Red blood cell disorders:** Anemia aplastic, anemia hypochromic. **Reproductive disorders, female:** Menorrhagia. **Respiratory system disorders:** Hemothorax. **Skin and appendage disorders:** Bullous eruption, rash erythematous, rash maculopapular, urticaria. **Urinary system disorders:** Abnormal renal function, acute renal failure. **White cell and reticuloendothelial system disorders:** Agranulocytosis, granulocytopenia, leukemia, leukopenia, neutropenia.

### Postmarketing Experience

The following events have been reported spontaneously from worldwide post-marketing experience:

- **Body as a whole:**
  - hypersensitivity reactions, anaphylactoid reactions, serum sickness
- **Central and Peripheral Nervous System disorders:**
  - confusion, hallucinations, taste disorders
- **Hepato-biliary disorders:**
  - abnormal liver function test, hepatitis (non-infectious), acute liver failure
- **Platelet, Bleeding and Clotting disorders:**
  - cases of bleeding with fatal outcome (especially intracranial, gastrointestinal and retroperitoneal hemorrhage)
  - thrombotic thrombocytopenic purpura (TTP) – some cases with fatal outcome – (see **WARNINGS**)
  - agranulocytosis, aplastic anemia/pancytopenia
  - conjunctival, ocular and retinal bleeding
- **Respiratory, thoracic and mediastinal disorders:**
  - bronchospasm, interstitial pneumonitis
- **Skin and subcutaneous tissue disorders:**
  - angioedema, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, lichen planus
- **Renal and urinary disorders:**
  - glomerulopathy, increased creatinine levels
- **Vascular disorders:**
  - vasculitis, hypotension
- **Gastrointestinal disorders:**
  - colitis (including ulcerative or lymphocytic colitis), pancreatitis, stomatitis
- **Musculoskeletal, connective tissue and bone disorders:**
  - myalgia

### OVERDOSAGE

Overdose following clopidogrel administration may lead to prolonged bleeding time and subsequent bleeding complications. A single oral dose of clopidogrel at 1500 or 2000 mg/kg was lethal to mice and to rats and at 3000 mg/kg to baboons. Symptoms of acute toxicity were vomiting (in baboons), prostration, difficult breathing, and gastrointestinal hemorrhage in all species.

### Recommendations About Specific Treatment

Based on biological plausibility, platelet transfusion may be appropriate to reverse the pharmacological effects of PLAVIX if quick reversal is required.

### DOSAGE AND ADMINISTRATION

#### Recent MI, Recent Stroke, or Established Peripheral Arterial Disease

The recommended daily dose of PLAVIX is 75 mg once daily.

#### Acute Coronary Syndrome

For patients with non-ST-segment elevation acute coronary syndrome (unstable angina/non-Q-wave MI), PLAVIX should be initiated with a single 300-mg loading dose and then continued at 75 mg once daily. Aspirin (75 mg–325 mg once daily) should be initiated and continued in combination with PLAVIX. In CURE, most patients with Acute Coronary Syndrome also received heparin acutely (see **CLINICAL STUDIES** in the full prescribing information).

For patients with ST-segment elevation acute myocardial infarction, the recommended dose of PLAVIX is 75 mg once daily, administered in combination with aspirin, with or without thrombolytics. PLAVIX may be initiated with or without a loading dose (300 mg was used in CLARITY; see **CLINICAL STUDIES** in the full prescribing information).

#### Pharmacogenetics

CYP2C19 poor metabolizer status is associated with diminished response to clopidogrel. The optimal dose regimen for poor metabolizers has yet to be determined. (See **CLINICAL PHARMACOLOGY: Pharmacogenetics** in the full prescribing information.)

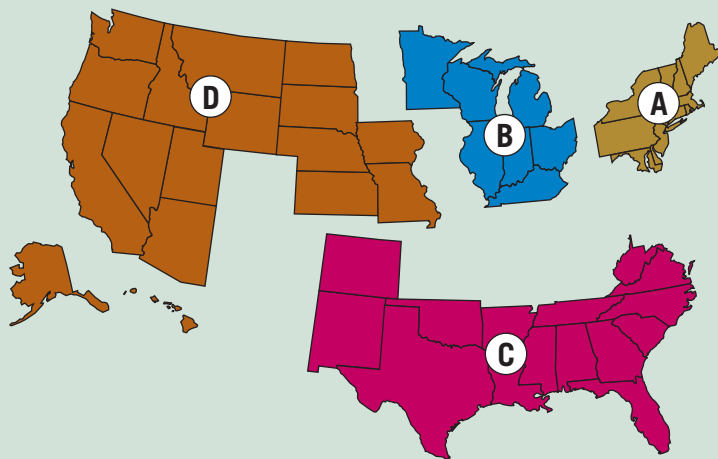
No dosage adjustment is necessary for elderly patients or patients with renal disease. (See **CLINICAL PHARMACOLOGY: Special Populations** in the full prescribing information.)

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## Recovery Audit Contractor Jurisdictions



Source: Centers for Medicare and Medicaid Services

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