The Medicaid Recovery Audit Contractor Snapshot

Medicaid Recovery Audit Contractors (RACs) identify and correct improper Medicaid payments through the collection of overpayments and reimbursement of underpayments made on claims for health care services provided to Medicaid beneficiaries. Section 1902(a)(42)(B)(i) of the Social Security Act requires States and territories to establish Medicaid RAC programs.[1] Currently, only providers who bill services through the State's Fee-For-Service Medicaid program and are paid under Title XIX of the Social Security Act are subject to review by the RAC.[2] Children's Health Insurance Program (CHIP) claims are not included within the scope of Medicaid RAC review. However, States are not precluded from reviewing CHIP claims to identify overpayments or underpayments.[3]

While Federal regulations set Medicaid RAC program requirements,[4] States have considerable flexibility regarding the design, procurement, and operation of their RAC programs.[5] Medicaid RACs are paid from amounts recovered on a contingent fee basis.[6] The Centers for Medicare & Medicaid Services (CMS) does not dictate contingency fee rates, but established a maximum contingency rate for which Federal financial participation will be available.[7]

Federal regulations also require the Medicaid RAC to work with the State to develop an education and outreach program, which includes notifying providers of RAC audit policies and protocols.[8] The RAC must notify providers of overpayment findings within 60 calendar days,[9] as well as refer suspected cases of fraud or abuse to the State in a timely manner.[10]

Providers should always be prepared for RAC audits. They may save valuable time and resources if they are in the position to respond to the RAC's requests as soon as possible and if any overpayments or improper billing practices are identified and corrected prior to the audit.

To prepare for RAC audits and help avoid future improper payments, providers should consider taking proactive steps such as:

- Assess billing procedures to ensure compliance with Medicaid billing requirements;
- Determine if there are billing mistakes in their claim history that would trigger a CMS investigation;
- Implement a process for responding to the RAC inquiries;
- Conduct a self-audit on a subset of claims to determine if they are in compliance with Medicaid requirements; and
- Train organizational providers on proper documentation for code levels, and the need to be familiar and compliant with Medicaid billing requirements.

For More Information

To see the electronic version of this and other E-Bulletins and for more information on other program integrity topics posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

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