Recovery Audit Contractors (RAC)

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RAC Legislation

Medicare Prescription Drug, Improvements and Modernization Act of 2003, Section 306
- Required 3-year RAC demonstration (other states: NY, MA, FL, SC and CA) – March 2005 through March 2008

Tax Relief and Healthcare Act of 2006, Section 302
- Requires a permanent and nationwide RAC program by January 1, 2010

Note: Both gave CMS authority to pay RACs on a contingency fee basis – 9% in Texas
RAC Defined

Recovery Audit Contractor Program

- cost containment effort
- detect and correct past improper payments
- CMS lower error rate
- Protect taxpayers and future Medicare beneficiaries
- identify process improvements to reduce or eliminate future improper payments
- RACs will not replace current review entities (i.e. Medicare contractors, OIG, etc.)

Why RACs?

Top 8 Federal Programs with Improper Payments (2007)

- EIT Credit - $11.48
- Medicare - $10.88
- Medicaid - $12.98
- SSI - $4.18
- OAS Ins./Unempl. Ins. - $2.58
- Nat’l School Lunch - $1.48
- Food Stamps - $1.88
- Other - $6.78

* - 2008 Error Rate for FFS decreased from 3.9% to 3.6%; CMS estimates to have saved over $400M in last FY

Of all agencies reporting to OMB in 2007, these 8 make up 88% of the improper payments.

Medicare receives over 1.2 billion claims per year, which equates to ~4.5 million claims per work day.

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Why RACs?
Some Statistics from the Demonstration

- During 3-year demonstration project, **over $1 billion** recovered
  - 96% of improper payments were overpayments
  - 22.5% of overpayment determinations were appealed
  - 7.6% of overpayment determinations were reversed
  - 85% of overpayment recoveries came from inpatient hospital services, but...
- When trying to determine whether RACs will be interested in physician practices – *See bullet point #1*

Who are the RACs?

- CMS divided country into 4 regions and selected a RAC for each region
- A – Diversified Collection Services
  - Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
- B – CGI Technologies and Solutions
  - Indiana, Illinois, Kentucky, Ohio, Michigan, Minnesota, and Wisconsin

*continued...*
Who are the RACs?

- **C – Connolly Healthcare Associates**
  - Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, **Texas**, Virginia, West Virginia, territories of Puerto Rico and Guam

- **D – HealthDataInsights**
  - Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Montana, Missouri, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming

Who does RAC affect and when will RAC affect Providers?

- Providers that receive Medicare fee-for-service payments
- January 2010
RAC Review Process

- RACs review claims on a post-payment basis
- RACs look for overpayments and underpayments
- RACs use same Medicare policies as others (i.e. CMS manuals)
- 3 year look back, but not prior to October 1, 2007
- RACs employ certified coders, nurses, therapists and physician medical directors

Common Reasons for “Overpayments” in RAC Demonstration Project

- “Medically unnecessary” payments
- Improper coding
- Insufficient documentation
Traditional Medicare Process
v.
RAC

Physician provides service
Physician provides service

Physician submits claim

(Prepayment review)

Medicare denies payment

Physician appeals
Physician provides service

Physician submits claim

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Medicare makes payment

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Standard post-payment reviews
1/11/2013

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3-year “look back” period

RAC audit

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Physician appeals

3-year “look back” period

But only as far back as October 1, 2007

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**RAC Reviews**

- 2 types of RAC reviews
  - **Automated** (no medical record needed)
    - Data mining to find inaccurate payments
    - *e.g.*, duplicate services
  - **Complex** (medical record required)
    - Record reviewed to determine if payment is accurate
    - Timelines are important if a complex review is requested
    - *e.g.*, medical necessity
Yes – Complex Review (Medical Records)

- RAC requests additional documentation from provider 45 + 10 calendar days mail time to submit
- RAC has 60 days to review documentation
- RAC makes claim determination
- RAC issues results letter to provider
- RAC sends claim into carrier, FI or MAC, and carrier, FI or MAC adjusts and issues remittance advice
- Day 1 RAC issues demand letter
  - includes amount
  - describes appeal rights
- Day 41 carrier recoups by offset

Prepare to Respond to RAC Medical Record Requests

- When necessary, check on the status of the medical record (e.g., Did the RAC receive it?)
  - Call the RAC
- Communicate, communicate, communicate
**Additional Documentation Request Limits**

Physicians:

- **Sole practitioner:** 10 medical records per 45 days per group NPI
- **Partnership 2-5 doctors:** 20 medical records per 45 days per group NPI
- **Group 6-15 doctors:** 30 medical records per 45 days per group NPI
- **Group 16+ doctors:** 50 medical records per 45 days per group NPI

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**No – Automated Review (Data Analysis)**

- RAC makes a claim determination
- RAC sends claim information to carrier, FI or MAC
- Carrier, FI or MAC adjusts and carrier, FI or MAC issues remittance advice to provider
- Day 1 RAC issues demand letter
  - includes amount
  - describes appeal rights
- Day 41 carrier, FI or MAC recoups by offset
RAC Collection Process

- What is different from Carriers, FIs, and MACs?
- Demand letter is issued by the RAC
- RAC offers opportunity for the provider to discuss the improper payment determination with the RAC (outside the regular appeal process)
- Issues to be reviewed by the RACs will be approved by CMS prior to general use
- Approved issues will be posted to a RAC website prior to general use

Key Dates - Recoupment

- Discussion Period: 40 days
- Repayment Plans: Immediately but not > 40 days
- Recoupment: 41st day

Note: You may stop recoupment if notice of appeal clearly marked “OVERPAYMENT APPEAL” filed within 30 days.
- Appeal (1st level): 120 days
Provider Options
When RAC Determines Overpayment

- Pay by check
- Recoupment from future payments
- Apply for extended repayment plan
- Appeal (same as Medicare appeals process except for Part A inpatient hospital claims under Prospective Payment System (PPS)).

Medicare Appeals Process

<table>
<thead>
<tr>
<th>Level of Appeal</th>
<th>Filing Deadline</th>
<th>Decision Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Redetermination</td>
<td>120 days</td>
<td>60 days</td>
</tr>
<tr>
<td>2. Reconsideration</td>
<td>180 days</td>
<td>60 days</td>
</tr>
<tr>
<td>3. ALJ Hearing</td>
<td>60 days</td>
<td>90 days</td>
</tr>
<tr>
<td>4. MAC Review</td>
<td>60 days</td>
<td>90 days</td>
</tr>
<tr>
<td>5. Federal Court</td>
<td>60 days</td>
<td>No set timeline</td>
</tr>
</tbody>
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**Appeal Levels**

- First Level of Appeal: Redetermination
  - Provider has 120 days to file request for redetermination
    - Issue in RAC demonstration – Providers did not always receive notice of denial from the RACs
  - Must request the redetermination within **30** days in order to avoid recoupment
  - Should be noted that following initial denial, there is a period of discussion with the RAC
  - Providers can take advantage of this period of discussion to try and resolve the claim with the RAC
  - The RAC discussion period does not toll the appeals deadlines
  - No amount in controversy required
  - Must be in writing

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**To Allow Recoupment Or Not to Allow Recoupment: That Is The Question**

- If recoupment is not allowed:
  - Must appeal within **30** days
  - If the appeal is lost, interest is accruing at rate of approximately 12% and that rate is adjusted quarterly
  - Must have a decision maker in place to decide on a case-by-case basis whether to allow recoupment or have an organizational philosophy in place
2nd Level of Appeal: Reconsideration

- If the Provider is dissatisfied with a redetermination, can file a request for reconsideration with QIC
- Must be filed within 180 days or 60 days to avoid recoupment
  - No amount in controversy required
  - “Not an in-person hearing”
  - Must submit all evidence at this stage of appeals process
  - Failure to do so may prevent use of additional evidence in the appeals process without good cause

2nd Level of Appeal: Reconsideration (cont’d)

- “On the record” review by the QIC of the initial determination and redetermination
- Any medical necessity reviews are to be performed by appropriate healthcare professionals and based on the patient medical records, scientific evidence and clinical experience
- Bound by National Coverage Decisions, CMS rulings and applicable laws and regulations
- Not bound by Local Coverage Decisions, CMS program guidance, or Local Medical Review Policies
3rd Level of Appeal: 
ALJ Hearing

- Provider dissatisfied with a reconsideration decision by the QIC may request a hearing before an ALJ
  - Must be filed within 60 days
  - Hearing conducted by phone or via teleconference
  - Can be conducted in person
  - Hearings for Texas are conducted out of Miami
  - ALJ will review any of the evidence presented through QIC level

3rd Level of Appeal: 
ALJ Hearing (cont’d)

- New evidence only admitted for good cause
- Oral testimony extremely important
  - Educate witnesses on issues that are the focus of the review
- Discovery permitted only when CMS elects to participate as a party
  - But providers may make a request for a copy of a QIC’s notes and also the ALJ’s hearing file
- CMS and the RACs can participate in the ALJ hearing without joining as a party or as a party.
- If the appeal from the QIC is an appeal as a result of an alleged overpayment in which the QIC is relying on a statistical sample to make its decision, the ALJ must base his or her decision on reviewing all claims in the sample.
- ALJ has 90 days to issue ruling
4th Level of Appeal: Medicare Appeals Council

- Unfavorable ruling from ALJ – request review from MAC
- Request must be made within 60 days
- CMS or any of the contractors can refer case to the MAC
- MAC may elect to review the ALJ's decision
- Generally there is no oral hearing
- Appeal limited to evidence submitted to ALJ
- MAC has 90 days to issue a decision

5th Level of Appeal: Federal District Court

- Can appeal MAC ruling in Federal court
- Must be done within 60 days
- Must name Secretary of HHS in Petition
- Evidence limited to the Administrative Record
- Findings of fact of the Secretary of HHS, if supported by substantial evidence, are deemed conclusive
- Cost vs. Benefit Analysis comes into play
Risk to RAC

If RAC loses at any stage of appeal, RAC must return contingency fee.

Whether To Appeal

• Who Will Make The Decision Whether To Appeal An Unfavorable RAC Audit Determination?
  • Consider having in place a decision process with a single individual responsible for deciding whether to pursue the appeal at the outset with financial and clinical input
How Appeals Can Go Wrong

- Improper documentation
- Ineffective written responses
- Missed deadlines
- No system for tracking appeals
- Hidden terminology traps
- No appeal at all

RAC Appeal Process

- Deadline-Sensitive
  - Must have system in place to track deadlines
  - Have an individual dedicated to monitoring appeal deadlines
  - Same individual should be involved in tracking RAC-related record requests and responses
- Other Tracking
  - Track internally the claims and areas subject to review
  - Utilize the RAC website to identify areas of review
  - Utilize the CMS website to identify areas of improper payments
How can you get ready?

- Prepare within the office
- Know where previous improper payments have been found
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC medical record requests
- Remember that RACs are just one part of the health care enforcement framework

Prepare within the Office

- Identify and maintain a RAC contact point to manage correspondence
- Review and update (as needed) your current compliance program/policies
- Implement internal procedures to respond promptly to RAC requests
- Familiarize yourself with the Medicare appeal process and be prepared to appeal if you disagree with the RAC findings
- Take advantage of the “discussion” period