

GET READY... RECOVERY AUDIT CONTRACTORS ARE COMING TO MICHIGAN

Andrew B. Wachler, Esq.
Abby Pendleton, Esq.
Jessica L. Gustafson, Esq.

Wachler & Associates, P.C.
210 E. Third St., Ste. 204
Royal Oak, MI 48067
(248) 544-0888
www.wachler.com

Medicare providers and suppliers nationwide can soon expect to see increased scrutiny of Medicare claims. The Centers for Medicare and Medicaid Services (“CMS” or “Medicare”) Recovery Audit Contractor (“RAC”) program has been made permanent and is now expanding nationwide. Medicare providers and suppliers in Michigan will be some of the first to experience RAC audits and claim denials under this permanent program. This article will provide an overview of the RAC program and will provide guidance to Medicare providers and suppliers that soon may find themselves subject to RAC audits.

Recovery Audit Contractors

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (“MMA”) mandated that the Secretary of the Department of Health and Human Services (“HHS”) conduct a three-year demonstration program using RACs to determine whether the use of RACs would be a cost-effective way to identify and correct improper Medicare payments. The RAC demonstration program began in 2005 in the three states with the highest Medicare expenditures: California, Florida and New York. In 2007, the program expanded to include Arizona, South Carolina and Massachusetts. The RACs were private companies tasked to identify and recoup Medicare overpayments and identify underpayments, and were compensated on a contingency fee basis based upon the principal amount collected from and/or returned to the provider or supplier. The RAC demonstration program concluded March 27, 2008.¹ The

¹ <http://www.cms.hhs.gov/RAC>

demonstration proved highly “cost-effective” from the point of view of CMS.² Throughout the course of the three-year demonstration program, the RACs identified and collected more than \$1.03 billion in improper payments. CMS estimates that the RAC demonstration program cost approximately only 20 cents for each dollar returned to the Medicare Trust Funds.³

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required its expansion nationwide by no later than 2010,⁴ but CMS already has begun to expand the program nationally. According to its most-recently published “Expansion Schedule,” CMS planned to expand to 19 states by October 1, 2008 (including Michigan), four more states by March 1, 2009, and the remaining states by August 1, 2009 or later.⁵

On October 6, 2008, CMS announced the names of the RAC vendors for the permanent program, and identified the initial states for which each will be responsible. The RAC vendor assigned to Michigan is CGI Technologies and Solutions, Inc. of Fairfax, Virginia.⁶

Before the RACs begin auditing in the permanent program, the RACs will hold outreach meetings, at which the RACs will meet with representatives from CMS and with providers and suppliers. In Michigan, this outreach was originally scheduled to take place on November 6, 2008 with a presentation to the Michigan Health and Hospital Association.⁷ However, due to protests initiated by two companies that unsuccessfully bid to become RACs for the permanent

² “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 14, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

³ *Id.* at p. 15.

⁴ Section 1893 (h) of the Social Security Act, 42 U.S.C. § 1395ddd.

⁵ RAC Expansion Schedule, *available at* <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

⁶ <http://www.cms.hhs.gov/RAC>

⁷ *See* RAC Provider Outreach Schedule, *available at* <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Provider%20Outreach%20Schedule%20for%201st%20Wave%20States.pdf> (last accessed November 16, 2008).

program, all RAC activity (including outreach meetings) have been delayed, possibly until February 2009.⁸ However, soon after decisions are rendered on the protests and the outreach meetings are completed, Michigan Medicare providers and suppliers can expect to receive requests for medical records and/or overpayment demand letters from the RACs.⁹

The RAC review process

Although the RACs are tasked to identify all types of improper payments (i.e., underpayments and overpayments), it is the process of identifying and recouping alleged overpayments that is of particular significance to Medicare providers.¹⁰ RACs are permitted to attempt to identify improper payments resulting from incorrect payments, non-covered services (including services denied as not medically necessary), incorrectly coded services (including DRG miscoding), and duplicate services.¹¹ RACs are prohibited from selecting claims at random to review.¹² Instead, RACs use proprietary “data analysis techniques” to determine claims likely to contain overpayments, a process known as “targeted review.”¹³

⁸ In early November 2008, two companies that unsuccessfully bid for contracts under the permanent RAC program, PRG Schultz (the RAC for California during the RAC demonstration program) and Viant, Inc., filed formal protests of the RAC contract awards with the Government Accountability Office (“GAO”) under the Competition and Contracting Act of 1984 (“CICA”). As a result of these protests, CMS imposed an automatic stay of all contract work of the RACs pending a decision by the GAO. Under CICA, the GAO must issue its decision on the protests within 100 days. Therefore, the RAC contracts, and all associated work, may be on hold until February 2009. See <http://www.cms.hhs.gov/RAC> (last accessed November 11, 2008) and <http://www.gao.gov>. Interested persons can access the status of these protests from the GAO’s website. See <http://www.gao.gov/legal/index.html>.

⁹ 2008 RAC Fact Sheet, available at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

¹⁰ “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 15, June 2008, available at http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

¹¹ See generally, “Statement of Work for the Recovery Audit Contractor Program,” available at https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

¹² 42 U.S.C. § 1395ddd.

¹³ “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at pp. 8-9, June 2008, available at http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

RACs engage in two types of claim reviews in order to identify improper payments: “automated review” and “complex review.” An “automated review” is a review of claims data without a review of the records supporting the claim. A “complex review” is a review of medical or other records, and is used in situations where there is a high probability (but not a certainty) that a claim includes an overpayment.¹⁴

In summary, the RAC “complex review” process is as follows:

- The RAC will either (a) visit the provider’s location to view and/or copy medical records necessary for its review, or (b) request that the provider mail, fax, or otherwise securely transmit the records to the RAC.¹⁵ During the RAC demonstration program, some providers felt burdened by the volume of records requests received from the RACs. In an effort to address this concern, CMS has imposed limits on the number of records RACs may request per 45-day period in the RAC permanent program.¹⁶

Despite these limits, providers still may find it challenging to timely respond to the volume of records requests received. It is essential that providers timely respond to a RAC’s request for medical records. Significantly, if a RAC does not receive requested medical records within 45 days, it is authorized to render an overpayment determination with respect to the underlying claim. If the provider or supplier appeals this type of denial, Medicare is not required to reopen the claim and consider the appeal. Thus, providers failing to timely respond to RACs’ medical records requests could lose appeal rights with respect to these claims.¹⁷

- Once requested medical records are received, the RAC will conduct its review of the claim. In conducting reviews, RACs are required to comply with National Coverage Decisions (“NCDs”), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, Local Coverage Decisions (“LCDs”), and local coverage and coding articles in their respective jurisdictions.¹⁸

¹⁴ *Id.*

¹⁵ *Id.* at p. 11.

¹⁶ See “RAC Medical Record Request Limits,” available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf>.

¹⁷ See “Statement of Work for the Recovery Audit Contractor Program” at p. 13, available at https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

¹⁸ *Id.* at p. 16.

- Generally speaking, a RAC must complete complex reviews within 60 days from receipt of the requested medical records.¹⁹ Following its review, the RAC will issue a letter to the provider setting forth the findings for each claim and notifying the provider of its appeal rights.²⁰ Alleged overpayments identified by RACs may be appealed through the uniform Medicare appeals process.

RAC Planning and Compliance

Although providers and suppliers cannot stop RAC audits from happening, they can enact systems for tracking record requests and timely responding, implement appropriate compliance programs, and make efforts to understand available audit defenses. Specifically, Medicare providers and suppliers should enact systems to address the following:

- Responding to record requests within the required timeframes;
- Internally monitoring protocols to better identify and monitor areas that may be subject to review;
- Implementing compliance efforts, including, but not limited to, documentation and coding education; and
- Properly working up appeals to challenge denials in the appeals process.

Although it cannot be predicted with certainty the areas that will be subject to review during the permanent RAC program, the Office of Inspector General (“OIG”) publishes an annual Work Plan document, which sets forth projects the OIG plans to address during the upcoming fiscal year, including areas of planned audit activity. In addition, reviewing the types of denials made during the RAC demonstration program is a helpful tool for Medicare providers and suppliers to identify potential target areas for the RACs operating in the permanent program.

During the RAC demonstration program:

- The vast majority (85 percent) of claim denials involved inpatient hospital claims;
- Six percent of claim denials involved inpatient rehabilitation facility (“IRF”) services;

¹⁹ *Id.* at p. 19.

²⁰ *Id.* at p. 22.

- Four percent of claim denials involved outpatient hospitals;
- The remaining denials involved the claims of physicians, skilled nursing facilities, durable medical equipment suppliers and ambulance, laboratory or other providers.²¹

Medicare providers and suppliers can expect to see similar audit activity during the RAC permanent program. In addition, on October 6, 2008, CMS announced its plan to focus its upcoming review activities on home health agencies (which were exempt from the RAC demonstration program) and durable medical equipment suppliers in Michigan specifically.²²

Of the denials made by RACs during the demonstration program:

- 35 percent of the improper payments identified were the result of incorrect coding;
- 40 percent were denied because the claims did not meet Medicare’s medical necessity criteria; and
- Eight percent were denied for the reason, “no/insufficient documentation” (meaning the RAC requested the information but the entity did not respond timely or completely).
- 17 percent were denied for “other” reasons, including that claims were paid based upon outdated fee schedules, duplicate claims, etc.²³

Medicare providers and suppliers are advised to adopt and implement compliance policies and procedures to address these and other areas of Medicare scrutiny now, before the RACs begin auditing in the permanent program.

²¹ “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 38, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

²² “CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse in Medicare,” October 6, 2008 Press Release, *available at* <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3291&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>.

²³ “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at pp. 1 and 19, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

RAC and Medicare Audits: Strategies for Successfully Appealing Claim Denials

If a Medicare provider or supplier receives a claim denial, or a finding of overpayment is made as a result of a RAC review, this denial will be subject to the uniform Medicare Part A and Part B appeals process.²⁴ The five-stage appeals process is as follows:

- Redetermination
- Reconsideration
- Administrative Law Judge ("ALJ") hearing
- Medicare Appeals Council ("MAC") review
- Federal district court review.

Medicare providers and suppliers subject to RAC or other Medicare audits and claim denials should understand that many strategies exist that can be employed in the appeals process to effectuate successful results. These strategies involve effectively advocating the merits of the underlying claim and employing legal defenses.

When advocating the merits of a claim, it is useful to draft a position paper outlining the factual and legal arguments in support of payment for a disputed claim. Other strategies that can prove successful include the use of medical summaries, illustrations, and color-coded charts or graphs depicting the claims at issue that are user-friendly for the decision maker. Additionally, in most cases, it is advantageous to engage the services of a qualified expert, particularly when an audit or claim denial involves issues of medical necessity. In addition to advocating the merits of a claim through various techniques, certain legal defenses are available. A qualified health care attorney can assist Medicare providers and suppliers in navigating through the Medicare appeals process and successfully applying appropriate legal defenses.

²⁴ The regulations governing this process are contained at 42 C.F.R. § 405.900 *et seq.*

Michigan Medicare providers and suppliers should prepare now for increased Medicare scrutiny as the RAC program expands into Michigan. Providers and suppliers should act now to evaluate their compliance with Medicare policies and guidelines. Should a Medicare provider or supplier be subject to a RAC or other Medicare audit, effective strategies are available that can be successfully employed in the appeals process to challenge denied claims.