



**AOA Bureau of Hospitals**

**Recovery Audit Contractor Program**

**Fredric J. Entin**

March 11, 2010



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**Obama takes health care overhaul push to Missouri**

“Obama's message Wednesday ...The plan he's touting would bring in high-tech bounty hunters to help root out health care fraud...”

The bounty hunters in this case would be private auditors armed with sophisticated computer programs to scan Medicare and Medicaid billing data for patterns of bogus claims. The auditors would get to keep part of any funds they recovered. The White House said a Medicare pilot program recouped \$900 million for taxpayers from 2005-08.”

St. Louis, 3/10/10 Associated Press



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**Background**

- Medicare Modernization Act of 2003 established the Medicare Recovery Audit Contractor Program (“RAC”)
- Purpose: to identify improper Medicare payments (both overpayments and underpayments)
  - not to detect fraud
- Independent contractors, no government investment in personnel or technology



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## Background

- RAC's paid on contingency basis-9%-12.45% depending on the contractor
- RAC's audit:
  - Hospital inpatient and outpatient;
  - Skilled nursing facilities;
  - Physicians;
  - Ambulance and laboratory;
  - Durable medical equipment.

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## Background

- RAC's use proprietary software programs to identify errors
- Have access to electronic files of the Medicare Administrative Contractors (MAC)
- Tax Relief and Health Act of 2006 made RAC Program permanent and authorized CMS to expand program to 50 States by 2010.

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## RAC Demonstration Project

- 3 Year Project-March 2005-March 2008
- California, New York, Florida, Massachusetts, South Carolina
- \$1.06 billion in improper payments corrected
- \$992.7 million overpayments
- CMS calculated that it spent only 20 cents for each dollar collected by RACs

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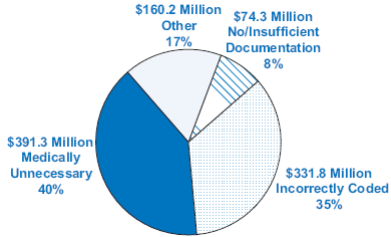
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## RAC Demonstration Project Overpayments by Error Type



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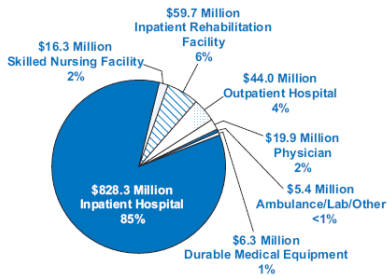
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## RAC Demonstration Project Overpayments by Provider Type



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## Permanent RAC Program

### Key Changes from Demonstration Project

- ✓ Look Back Period
  - ✓ Demonstration: 4 years
  - ✓ Permanent: 3 years but not earlier than October 1, 2007
- ✓ Contingency Fee
  - ✓ Demonstration: Only return fee if overturned at first level of appeal
  - ✓ Permanent: Must return if provider prevails at any level of appeal
- ✓ Records Request
  - ✓ Demonstration: Each RAC set own limit
  - ✓ Permanent: specific limits

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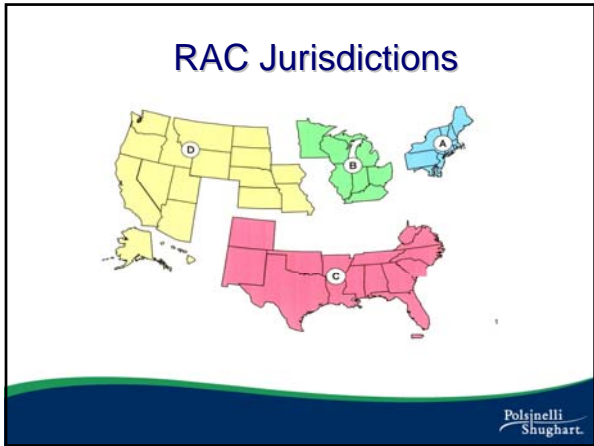
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## RAC Contractor Contact Information

RAC	Website	E-mail	Telephone Number
Region A: Diversified Collection Services	<a href="http://www.dcsrac.com">www.dcsrac.com</a>	<a href="mailto:info@dcsrac.com">info@dcsrac.com</a>	1-866-201-0580
Region B: CGI	<a href="http://racb.cgi.com">http://racb.cgi.com</a>	<a href="mailto:Racb@cgi.com">Racb@cgi.com</a>	1-877-316-7222
Region C: Connolly Consulting	<a href="http://www.connollyhealthcare.com/RAC">www.connollyhealthcare.com/RAC</a>	<a href="mailto:RACinfo@connollyhealthcare.com">RACinfo@connollyhealthcare.com</a>	1-866-360-2507
Region D: HealthDataInsights	<a href="http://racinfo.healthdatainsights.com">http://racinfo.healthdatainsights.com</a>	<a href="mailto:Racinfo@emailhdi.com">Racinfo@emailhdi.com</a>	Part A: 866-590-5590 Part B: 866-376-2319

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## TWO TYPES OF RAC Reviews

***Automated Review:*** Data mining

- Claims data without records
- Won't know they are looking at your claims until get a demand letter

***Complex Review:*** Data analysis

- Review of medical or other records
- High probability that a claim includes an overpayment

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## AUTOMATED REVIEWS

No Medical Records Needed for Review

RACs may use automated review **ONLY** in situations where there is certainty that the claim contains an overpayment.

- a) have clear policy that serves as the basis for the overpayment ( a statute, regulation, National Coverage Determination, coverage provision in an interpretive manual, or Local Coverage Determination that specifies the circumstances under which a service will **ALWAYS** be considered an overpayment);
- b) be based on a medically unbelievable service; or
- c) occur when no timely response is received in response to a medical record request letter.




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## COMPLEX REVIEW

Based on the Medical Record

- Medical Record Request
  - Limits set at 1% of all claims submitted for the previous calendar year, divided into 8 – 45 day periods, subject to a cap
  - Through March 2010, cap at 200 requests/45 days
  - April – Sept, 2010, cap at 300 requests/45 days for providers who bill in excess of 100,000 claims to Medicare
- Each RAC must have at least on physician CMD FTE and nurses, therapists and coders
- RAC may audit single claims
  - or -
- RAC may extrapolate




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## Criteria Used by RACs

**Cannot develop or apply own policies**

Will audit for compliance with:

- ✓ Medicare Policies
- ✓ Medicare Regulations
- ✓ National Coverage Determinations
- ✓ Local Coverage Determinations
- ✓ Manual Instructions
- ✓ "accepted standards of medical practice"




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## RAC Reviews-No Surprises

- Any reviews initiated by the RAC must have been first approved by CMS and posted to the RAC websites.

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## Self-Audit

**A great opportunity, don't waste it!**

- **Get Ahead if the RACs**
- **Prioritize!**
  - Low hanging fruit-demonstration project
  - PEPPER Reports (Program for Evaluating Payment Patterns)
  - RAC websites
  - Review own denial trends
  - OIG Workplan
  - Use technology where possible
    - Internal resources or consultants

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## Self-Audit

**A great opportunity, don't waste it!**

- Before you get too far, engage legal counsel!
- Attorney-client, work product or self-critical analysis privileges give more control
  - Attorneys understand appellate process
- Identify improper payments
- Report to local carrier
  - Self Disclosure to OIG
  - RAC cannot audit claims reported (strategic issue)
- Extrapolate
- Ensure method used is correct under CMS standards
  - If done correctly, will preclude entire universe from RAC review
- Remediate! Cut off the exposure

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## Attorney Client Privilege

- Distribution of results beyond control group may destroy privilege
- May not be available for general rather than targeted internal audit
- Consultants/auditors should be retained by counsel
- Clearly label all documents used by counsel in audit
- Whether seeking legal advice or prepared in anticipation of litigation will be up to a judge

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## Self-Disclosure

### RISKS

- No precise formula for settlement
- May breach bond covenants if enter into settlement
- DOJ or another agency may bring civil or criminal actions
- May lose privilege when producing to OIG
- No turning back

### BENEFITS

- Interest does not accrue throughout process
- Information for disclosure obtained from internal audit
- If cooperative, OIG shows trend of settlement amount at lower continuum
- Cooperation a mitigating factor-may avoid CIA or CCA
- OIG advocacy if another agency brings action
- If a CIA, less onerous
- If cooperative, less likely information passed on to other agencies as ZPICs
- Precludes RACs from reviewing claims disclosed

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## RESPONSE TEAM

### RAC compliance requires efficiency and organization

- ✓ Form a Response Team
  - Financial
  - Patient Services
  - Compliance
  - Legal
  - Health Information Technology
- ✓ Centralize all mailings-deemed received 5 days after date on demand letter-no good if it sits in mailroom or on someone's desk
- ✓ Have clearly designated point people
- ✓ Create policies with internal deadlines corresponding to record production and appeals process
  - ✓ **Do not want to blow any deadlines!**

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## RAC Audit Process

### Request for Medical Records

- Deadline = 45 days from date request was mailed
- WARNING: Automatic denial if deadline is not met!**
- May request an extension of time from RAC

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## RAC Audit Process

### *Additional Documentation Limits – Institutional Providers - FY 2010*

- 1% average monthly Medicare episodes of care capped at 200 records every 45 days
  - Cap increases to 300 in April 2010
- Medical records cap per campus per 45-day period
  - Each campus = all facilities under the same TIN with the same first three positions of the ZIP code where they are physically.
    - ✓ Example 1: TIN 123456789 with facilities at zip codes 12345 and 12356 is one campus.
    - ✓ Example 2: TIN 123456780 with facilities at zip codes 12345 and 21345 is two campuses.

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## RAC Audit Process

### Extrapolation

- RAC may audit small sample of records, find overpayments, and extrapolate overpayment to provider's entire patient population
- Guidelines:* Medicare Program Integrity Manual (100-08), Chapter 3, Sections 3.10.1-3.10.11.2 (**RACs must follow; \*good point to appeal\***)
- Generally:* RACs use when (1) sustained or high level of payment error; or (2) documented educational intervention failed to correct payment error.

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## RAC Audit Process

### Demand Letter

- ❑ Upon determination of overpayment, Medicare fiscal intermediaries, regional home health intermediaries, and/or Medicare Administrative Contractors (Part A/B MACs) will adjust claims and trigger first demand letter
- ❑ Receipt of Demand Letter-**Presumed 5 days after date of demand letter**
- ❑ **Re-bill Part B?** If claim billed inpatient but does not meet medical necessity, can rebill as a Part B service. Time limit for re-billing claims is 15-27 months from the date of service.

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## RAC Audit Process

### Rebuttal

- **NOT A PART OF THE APPEAL PROCESS**
- **Deadline = 15 days** after date of demand letter
- Medicare contractor may, based on rebuttal statement, determine to move forward with recouping overpayment or halt the process.
- *Benefit:* Opportunity for informal communication with RAC to understand what RAC deems in error. Allows provider to use information to complete medical record to forward on in appeals.

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## Appeal Process

### Request for Redetermination

- **DEADLINE = 120 days from date of demand letter; file with carrier**
- **STOP RECOUPMENT!**  
File request by the 30<sup>th</sup> day following the date of the demand letter and before the 120<sup>th</sup> day will stop recoupment upon receipt.
- **Decision:** Contractor must render decision within 60 calendar days of the date contractor receives request.
- **Interest accrues on outstanding overpayments at current rate of 11.375%!**



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## Appeal Process



### Request for Reconsideration

- **DEADLINE = 180 days from date of redetermination decision with QIC [assume 5 days after date of decision]**
- **STOP RECOURPMENT!** File request by 60<sup>th</sup> day from redetermination decision
- **RECORD FOR APPEALS**-must present all evidence and arguments of fact or law related to issue; include all missing documents identified in notice of redetermination decision. **Absent extraordinary reasons the record for subsequent appeals is set!**
- Legal counsel should be involved before submit.
- **Decision:** QIC must render decision within 60 calendar days of date QIC receives request for reconsideration.

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## Recoupment



- Upon adverse reconsideration decision, recoupment **can begin or resume on day 30** from the date of the decision.
- MAKE PAYMENT ARRANGEMENTS** if choose to not pursue further appeals

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## Appeal Process

### Request for ALJ Hearing

- **Deadline = 60 days after receipt of QIC's decision**
- **Evidence:**
  - If new evidence, submit statement explaining why evidence was not previously submitted
  - **No explanation statement; evidence not considered!**
  - **Better to have complete record when request Reconsideration.**
- ALJ must render a decision within 90 days of receipt of request.

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## Appeal Process

### Medicare Appeals Council (MAC) Review

- **Deadline** = 60 days after receipt of ALJ's decision or dismissal
- Decision: MAC issues a final decision or remands the case to the ALJ within 90 days of receipt of appellant's request for review.

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## Appeals Process

### Federal District Court Review

- **Deadline** = 60 days from receipt of MAC decision
- Final level of appeal

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## Why appeal? \$\$\$

### CMS January 2009 Report

- Of 525,000 overpayment determinations made by RACs, providers appealed over 118,000 or 22.5%
- **34% overturned in provider's favor!**
  - CMS pays back any monies recouped + interest upon favorable decision

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### Provider's RAC Program Should Always Be Managed With Appeal in Mind

- Form Response Team and implement policies to ensure deadlines are met
  - blown deadlines not appealable
- Monitor protocols and identify areas that may be subject to review
  - RAC not always right and even if right, remediation cuts off liability
- Educate staff in coding and documentation
  - The guidance is out there. Prioritize based on self-audit.
- Be ready to appeal!
  - Challenge methods used by RAC
  - Even automated review can be wrong
  - Complex reviews are often judgment calls
  - Medical Necessity: Physician involvement
  - Coding: Coding consultants or internal expertise



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### Preparing For the RAC Audit & Appeals Process

- Contact Regional RAC
  - Develop a working relationship
  - Get all direct contact information
- Continuously Check RAC Web Site
  - RACs must develop web-based application by 2010 that allows providers to look up the status of medical record reviews
- Insurance
  - some products available. Covers costs of consultant, audit and legal fees



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### While you focus on RAC, don't forget about---

- MICs-Medicaid Integrity Contractors
- ZPICs-Zone Program Integrity Contractors
  - RACs will be referring cases suspected of fraud
- QIO-RACs will refer quality concerns
- OIG
- DOJ
- Medicaid Fraud Control Units
- **If a claim has been reviewed by any other entity, RAC cannot audit!**



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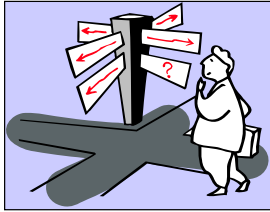
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## QUESTIONS?



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**Fredric J. Entin**  
Polsinelli Shughart PC  
161 N. Clark St., Suite 4200  
Chicago, Illinois 60601

(312) 873-3601  
fentin@polsinelli.com

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Shughart.

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**Margaret J. Hardy**  
American Osteopathic Association  
Director Hospital and Medical  
Educator Relations

(202) 414-0155  
mhardy@osteopathic.org

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