



MEMORANDUM

RE: Medicare Audit Recovery Contractors

Changes to the Medicare Audit Procedures

In response to concerns over improper Medicare billing and payments, Congress enacted Section 203 of the Tax Relief and Health Care Act of 2006. Section 203 requires the Secretary of the Department of Health and Human Services to use Recovery Audit Contractors (RACs) under the Medicare Integrity Program. The regulation mandates that the new Medicare auditing program be implemented nationwide by January 1, 2010. Due to these substantial changes, Medicare providers and suppliers need to be aware of the new process and the steps that can be taken to ensure compliance.

The new Medicare auditing program is an extension of the RAC demonstration enacted under section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Under the MMA, Congress instructed the Department of Health and Human Services to conduct a three year demonstration program. The program, which ran from 2005 to 2008, used Recovery Audit Contractors to identify improper Medicare payments through the detection and collection of overpayments and the identification of underpayments. The demonstration started in the three states with the highest percentage of Medicare claims: California, Florida, and New York. Later, the program expanded to include Massachusetts and South Carolina.

According to the Center for Medicare and Medicaid Services (CMS), the demonstration corrected over \$1.03 billion of improper payments. Of these improper payments, 96% were overpayments and 4% were underpayments. Most of the overpayments were collected from inpatient hospital providers.

CMS found that the demonstration was cost-effective for both RACs as well as Medicare providers and determined that the work of the RACS had a minimum financial impact on Medicare providers. Specifically, in Florida as well as New York, 90% of the hospitals that were audited during the demonstration had its 2007 Medicare revenue impacted by less than 2.5%. The program also posed little financial burden on the contractors. During the demonstration, it cost the RACs 20 cents for each dollar returned from overpayments. Based on these findings, and the apparent financial and practical success of the demonstration, Congress decided to initiate the nationwide expansion.

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Recovery Audit Contractors

Under the permanent program implemented by the Tax Relief and Health Care Act, four contractors were chosen through a competitive bidding process. Each contractor will serve a particular region of the United States. Connolly Consulting Associates, Inc. of Wilton, Connecticut will be the contractor for Florida and the rest of Region C, which is comprised of several southeast states. Connolly Consulting will also subcontract some of its audits to Viant Payment Systems, Inc.

The RACs are independent contractors that do not work directly for the government. Accordingly, they are subject to strict rules when auditing claims and are bound by Medicare policies, regulations, national and local coverage determinations, and manual instructions. The RACs will also receive a contingency fee between 9 and 12.5 percent of the amount of improper payments they discover, so they will actively search for overpayments. However, RACs are prohibited from selecting claims at random to view and instead, must use proprietary data techniques to find claims that are likely to contain overpayments. Moreover, if a RAC loses at any level of appeal, they must return the contingency fee.

The duties of the RAC are to identify underpayments or overpayments within past Medicare claims. In order to assist in the process, each RAC will employ a full time medical director to help review the claims. Additionally, RACs are required to employ nurses, therapists, certified coders, and full time physicians.

Who is Subject to Audits?

Based on the findings in the demonstration, certain groups will be subjected to Medicare audits under the new program. These groups include physicians, inpatient and outpatient hospitals, nursing homes, ambulance and laboratory services, home health agencies, durable medical equipment suppliers, and other providers or suppliers that bill Medicare parts A and B. The majority of audits are likely to come from inpatient hospitals, as they did in the demonstration.

RACs will generally look for the following types of improper payments within the claims to identify overpayments or underpayments:

- Payments made for services that were medically unnecessary
- Payments that did not meet Medicare medical necessity criteria
- Payments made for services that are incorrectly coded
- Provider's failure to submit documentation to support services provided
- Provider's failure to submit enough documentation to support a claim
- Payments made for duplicate services or services not covered

The Review Process

The two main activities of RACs will consist of performing data analysis to identify areas of investigation and requesting claims history information from carriers. The RACs will review claims on a post payment basis and use the same Medicare policies as Carriers, FIs and MACs during the review process. Generally, issues that are reviewed by RACs must be approved by CMS prior to widespread review. The approved issue must also be posted to the RAC website. For Florida, these issues will be posted at <http://www.connollyhealthcare.com/RAC>. However, sometimes a provider may receive a medical records request for a new issue that is not identified on an RAC website. If the RAC finds an overpayment, it will send a demand letter requesting recoupment. If an underpayment exists, the RAC will reimburse the provider.

Medicare claims will be subject to one of two types of review: automated review or complex review. Automated review occurs when the RAC looks for claims that clearly contain errors which result in improper payments. This type of review is conducted through data mining using proprietary techniques. Then, the RAC will contact the provider to collect the overpayment without reviewing any of medical records.

However, under complex review, the RAC looks at claims that likely contain errors resulting in improper payments. In this review, the RAC requests medical records to further review the claim. After reviewing the records, the RAC will then make a determination as to whether the payment was correct. If a request for medical records is made, the provider must furnish the requested records within 45 days. However, an extension may be requested. Additionally, the RAC must complete the review within 60 days of requesting the medical records. Then, if the RAC determines an overpayment exists after reviewing the claim, a demand letter will be sent to the provider in attempts to recoup the payment. The letter will explain the nature of the overpayment and how much the provider owes. The provider then has 30 days to pay the overpayment.

The Basic Timeline

15 Days

After receiving the demand letter, a provider has 15 days to rebut the RAC's determination. This is also called the discussion period. During this time, the provider has the opportunity to rebut the proposed recoupment if the provider can furnish additional information to show it was incorrect.

30 Days

A provider has 30 days after receiving the demand letter to pay the overpayment or to apply for a repayment plan. If a provider is unable to pay the amount of overpayment in full within the required 30 days, they can apply to gradually pay off the amount. Additionally, if the provider was not approved for a repayment plan and fails to pay the amount of overpayment on time, interest will be accruing.

40 Days

If no payment for recoupment has been paid within 40 days of receiving the demand letter, Medicare will begin to withhold payments. These payments will apply to current and future claims. Such payments will be withheld until the overpayment is fully paid along with any applicable interest or until an acceptable extended repayment request has been received.

Limitations on RACs

The new Medicare auditing process imposes some limitations on the RACs. Most of the limitations were not present in the demonstration, but will be applied to the permanent program as a response to some concerns stemming from the demonstration. First, RACs will only be permitted to review claims from the past three years under a limited look back period. Additionally, the RACs are not permitted to look for improper payments on claims made before October 1, 2007.

Secondly, there are several limitations on the amount of claims that may be reviewed. For inpatient hospitals, RACs cannot, within a 45 day period, request more than 10% of the hospital's average monthly Medicare claims. Also, the number of requests cannot exceed 200. Similarly, for outpatient hospitals, RACs cannot request more than 1% of the average monthly Medicare service within a 45 day period. Outpatient hospitals are also limited to no more than 200 requests.

Appeals Process

If a provider is unsatisfied with the determination made by the RAC, the provider has the option to appeal. The appeal process is contained in 42 C.F.R. § 405.900.

Apart from the discussion period, a provider has an opportunity to appeal determinations at five different levels. At the first level, called redetermination, a provider has 120 days to appeal from the date of the demand letter. The redetermination could lead to a full reversal, partial reversal, or full affirmation of the previous determination. If a provider is still unsatisfied with the result, it can file for the second level of appeal, reconsideration, within 180 days. The possible results of full reversal, partial reversal, or full affirmation are the same under reconsideration.

The third level of appeal involves bringing the issue in front of an Administrative Law Judge (ALJ). If at least \$120 remains in controversy, a party may request an ALJ hearing within 60 days of receipt of reconsideration. However, if the provider disagrees with the ALJ's determination, it can appeal to the fourth level which includes review by the Medicare Appeals Council. This appeal must be filed within 60 days of the receipt of the ALJ's determination. Lastly, the fifth level of appeal includes judicial review by a U.S. District Court. A request for this level of review must be filed within 60 days of receipt of the Medicare Appeals Council's decision.

What Providers Can Do to Prepare

There are many things Medicare providers can do to prepare for the upcoming increase of scrutiny within Medicare audits. First, providers should analyze past RAC findings and identify where improper payments have been persistent. Such information can be located on the RACs' websites and in the three year demonstration's results posted on the CMS website. With this information, providers should identify certain patterns of claims to be prepared for the types of claims RACs generally audit.

Next, providers should create an RAC response team. The team should consist of a group of individuals or department representatives that are capable of addressing the tasks associated with RAC reviews and audits. The members of the response team should represent several areas including compliance, utilization review, coding, medical staff, patient financial services, care management, and health information management. This team should perform an internal assessment to verify that submitted claims meet the Medicare standards and rules. It should also establish systems to monitor claim denials and appeals and to make sure the provider can respond timely to RAC record requests.

Additionally, the provider should utilize American Hospital Association's (AHA) RACTrac program. This program was created to monitor the RACs and to assure they adhere to Medicare policy. RACTrac also assesses the true impact of RACs on individual providers including financial impact of improper payments along with administrative burden. The program is a survey that will track and monitor the impact of RAC activity on individual hospitals nationwide. The AHA has also created a claim-level Excel tool to help hospitals internally track their RAC audits. The program will be available on the AHA web site at no cost to AHA members and non-members. Information under RACTrac will not be available until fall of 2009, but until then, providers should identify a mechanism to track all RAC correspondences.

Conclusion

The changes to the Medicare auditing process are substantial. They will increase the amount of claims that are audited, which in turn will likely increase the amount of administrative burden on Medicare providers. However, preparation can be taken to lessen the impact and ensure adequate compliance. If you need assistance with a Medicare audit issue, please feel free to call us.