Medicare's Recovery Audit Contractor (RAC) Program

IMGMA Spring Conference
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Vickie Brady Ahlers
Baird Holm LLP
1500 Woodmen Tower
Omaha, Nebraska 68102
(402) 344-0500
www.bairdholm.com

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RAC Demonstration Project

- 3-year RAC Demonstration Project
- Established by Medicare Prescription Drug, Improvement and Modernization Act of 2003
- Operated in CA, NY and FL from March 2005 through March 27, 2008
- Total of $992.7M in overpayments returned to the Medicare Trust Fund
- Underpayments repaid: $37.8M
- Overturned on appeal: $46M
- Costs to operate RAC Demonstration: $201.3
- Net savings to Trust Fund: $693.6M
- Cost-effective means of identifying under- and overpayments and recovering overpayments

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Recovery Audit Contractors: Status

- Tax Relief and Health Care Act of 2006 required HHS to make RAC program permanent and nationwide by 1/1/2010
- RAC outreach meetings underway nationwide; Iowa had meeting in August 2009
- Phase-in Strategy (blue states):
  - Black and White Issues; Automated Review, August 2009
  - DRG Validation; Complex Review, Oct/Nov 2009
  - Coding Error; Complex Review, Oct/Nov 2009
  - DME Medical Necessity Reviews; Complex Review, FY2010
  - Medical Necessity Reviews; Complex Review CY 2010

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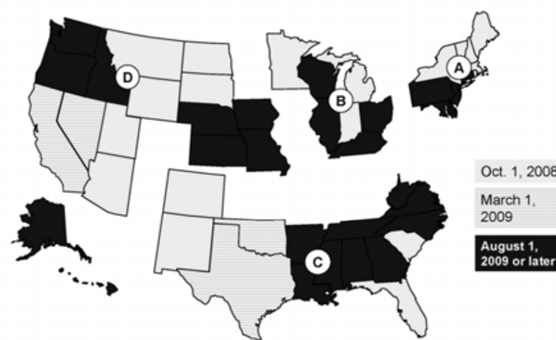

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Recovery Audit Contractor - HDI

- Region D – Health Data Insights ("HDI")
  - (Iowa, along with Midwest states of KS, NE, IL, ND, and SD)
- PRG-Schultz will serve as subcontractor
  - PRG Schultz not selected in original CMS bid due to large number of complaints
  - Touts on its website that during demonstration program, it identified over $330 million in improper payments
- Types of issues under review required to be listed on HDI website https://racinfo.healthdatainsights.com

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The Contingency Fee….

- RACs paid a contingency fee payment based on the amount of the improper payments they correct
  - Theoretically for both overpayments and underpayments
- RAC contingency fee negotiated with CMS by each contractor
  - Region A: 12.45%
  - Region B: 12.50%
  - Region C: 9.00%
  - **Region D: 9.49%**
- If overturned on appeal, fee must be paid back

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Lessons Learned from Demonstration Project

- RACs must employ a medical director to assist in review of claims
- Types of issues under review will be listed on RAC websites: “New Issues”
- Ongoing outreach efforts will be monitored so that no provider feels unreasonably burdened
- Lookback reduced from 4 years to 3
- Minimum claim amount changed from $10 aggregate claims to $10 minimal claims
- Discussion may be requested with CMD re claim denials under permanent program
- Credentials may be requested of reviewers

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Lessons Learned from Demonstration Project

- External validation will be required in in the permanent program
- Coding experts must be employed by RACs
- Maximum lookback date set at 10/1/2007
- RAC will be allowed to review claims in current year
- Medical record fee payments must be made within 45 days of receipt of records
- QA/Internal Control audit required in permanent program
- Reason for review will be listed on requests for medical records and overpayment letters
- By January 2010, there will be a website portal for review of RAC claims status

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Focus of RAC Efforts

- Incorrect payment amounts (except where CMS directs contractors otherwise)
- Noncovered services (including those not reasonably necessary)
- Incorrectly coded services (including DRG miscoding)
- Duplicate services

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Expansion to Medicaid

- Currently just for Medicare claims, but…
- Health Reform bill expands the RAC program to Medicaid services

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RAC Data Warehouse

- Risk of multiple agencies reviewing same claims:
  - RACs must check RAC data warehouse before beginning a claim review
    - Excluded claims: already under review by another agency or Medicare contractor
    - Suppressed claims: part of an ongoing fraud review or investigation

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Audit Process

- Claim selection
- Medical record requests
- Record review and status determination
- Post review notification
- Overpayment recoupment or Provider Appeal

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Claim Selection

- RAC may not review the same claim under review by another Medicare contractor, PSC, MAC or law enforcement agency
- RAC Data Warehouse used by the RAC to identify excluded claims which another entity already has the provider/claim under review
- May not target a claim solely because it is a high dollar claim

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New Issue Identification

- All new issues that are identified by HDI must first be approved by CMS
- Must be posted on RAC website
- Check out other RAC websites – will be coming to Region D if not already

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New Issue Identification

- As of 9/19/09
  - 7 issues on HDI website (https://racinfo.healthdatainsights.com/Public/NewIssues.aspx?State=NE)
  - BUT, 10 issues on Connolly Healthcare (Region C, including Colorado) website (http://www.connollyhealthcare.com/RAC/pages/record_submission.aspx)
- As of 4/5/10
  - 80+ New Issues approved by CMS on HDI website

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Automated Reviews

- Proprietary software algorithms to identify clearly improper payments detectable without a medical record review
  - Certainty that the service is not covered or is incorrectly coded
  - No manual/human reviewer intervention
  - Provider only notified when overpayments are identified
- Example 1 – Duplicate procedures
  - Two identical surgical procedures for the same beneficiary on the same day at the same hospital
- Example 2 – Excessive units
  - Billing 3 units of service for same day, same beneficiary when units should never exceed 1 for a single date of service

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Complex Reviews

- Detects likely improper payments after review of the medical record
  - Suspect claims with high probability of improper payment
  - Random sampling to identify cases
  - High probability, but need medical record to validate improper payment
- Example 1 – Diagnosis code on claim does not match diagnosis described in medical record
- Example 2 – Beneficiary's condition doesn't meet the medical necessity criteria for the setting where service rendered

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Medical Record Request Limits (Complex Reviews)

- *Physicians*:
  - Solo practitioner – 10 records/45 days
  - Partnership of 2-5 MDs – 20 records/45 days
  - Group 6-15 MDs – 30 records/45 days
  - 16+ MDs Group – 50 records/45 days

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Medical Record Requests

- Provider has 45 days to respond
  - If not received, RAC must initiate one additional contact
  - If no response, RAC can issue denial
- RAC pay charges for certain requests
  - Acute inpatient DRG for PPS hospitals
  - LTC claims

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Medical Record Requests

- Medical Record Photocopy Charges
  - RACs must pay for records of acute care PPS hospital claims and long term care hospital claims
  - RACs are permitted to pay for records from other claims – No apparent plans to do so
  - Rate is 12 cents per page, same for records submitted on discs
  - No requirement of submitting vouchers for reimbursement; payment is automatic to the facilities
  - RACs must pay monthly, and within 45 days of receiving the records

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Communicating with the RAC

- All correspondence from the RAC should come to single contact point or critical response dates/appeal deadlines may be missed
- RAC must allow providers to customize address
  - Each request must provide information on how to customize
  - Designate single contact point

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Coordination and Tracking the Status

- System should be in place to ensure timely review, copying and submission of medical records
- Appoint coordinator
- Avoid accessing documentation multiple times
- Most providers using either home-grown excel spreadsheets or proprietary software

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Types of Correspondence from RAC

- *Important to understand implications of each type of correspondence from RAC*:
  - Medical Record Request Letter
  - Review Results Letter
  - Demand Letter

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Types of Correspondence from RAC

- **Medical Record Request Letter**
  - Medical Record Request limits apply
  - Provider can respond either w/ hard copies or on a CD (no e-mail)
  - Provider has 45 days to postmark reply

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Types of Correspondence from RAC

- **Review Results Letter**
  - Will only receive after *Complex Review*
    - (after HDI's review of the medical records submitted by provider)
  - Will not specify amount of overpayment found
  - Will not include "appeal rights" information
  - Starts the "Discussion Period"

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Types of Correspondence from RAC

- **Demand Letter**
  - Starts the "Discussion Period" for Automated Reviews
  - Starts your ***Appeal*** clock for ***both*** types of review
  - Will include amount of overpayment (underpayment)
  - Can include multiple claims in same letter
  - Will include verbiage on your ***Appeal Rights***

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Discussion Period – What Is It?

- Term during demonstration project was "Rebuttal Period"
- RACs didn't like term – so CMS changed
- Opportunity to offer additional medical record documentation or other argument as to why RAC decision is incorrect
- "Theoretical" opportunity to talk to HDI medical director

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Discussion Period Request Form

REGION D RECOVERY AUDIT CONTRACTOR
DISCUSSION PERIOD SUBMISSION FORM
PART A, HOSPITAL AND HOSPICE CLAIMS

To: **HDI Part A Discussion Period Review** Fax: **702.240.5595**
From: Date:
Re: **Request to Open Discussion Period** Pages:

Please review the attached additional materials and re-evaluate the original improper payment determination for:

HDI Audit Number: ____________
Claim Number ____________
Provider Name: ____________
Provider Number: ____________

SUBMISSION INSTRUCTIONS:
You may submit this form and the additional materials by fax or mail.
NOTES:
1. PLEASE SUBMIT ONE FORM FOR EACH CLAIM.
2. PLEASE ENCLOSE A COPY OF THE AUDIT DETAIL FROM THE HDI LETTER
3. HDI WILL CAREFULLY REVIEW THE MATERIALS YOU HAVE SUBMITTED AND PROVIDE YOU WITH A WRITTEN RESPONSE.

CMS RAC Part A Discussion Period Review 7501 Trinity Peak St, Suite 110 Las Vegas, NV 89128
Part A Provider Relations: (866) 590-5598 Fax: (702) 240-5595

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Reviewer Qualifications

- Reviewer Qualifications
  - Coverage/necessity determinations must be made by RNs or therapists
  - Coding determinations must be made by certified coders

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RAC Review Results

- Automated review results will be reported only if an overpayment is found
- Complex review results must be reported even if no improper payment is identified
  - Letter must be sent within 60 days of exit conference for provider site reviews or of receipt of medical records for RAC site reviews
  - RACs may request waiver of 60 day period from CMS

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Underpayment

- RAC reports it to Medicare contractor
- Once validated by contractor, RAC sends a notice to provider including claim and beneficiary detail
- Medicare contractor will make claim adjustments
- No adjustment for underpayment less than $1
- No official appeal rights for underpayment determinations; rebuttal process may be used

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Overpayment

- RAC will not attempt to recoup or forward a claim to Medicare contractor if amount is less than $10
- No aggregation of claims less than $10
- No RAC authority to settle or compromise overpayments.
  - RAC will forward any such proposals to CMS
  - RAC demonstration project had less than 1% settlement of the total collections

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Overpayment

- Interest accrues on overpayment determinations from the date of final determination, charged on each 30 day period payment is delayed
- Payments received will be applied first to accrued interest and then to principal
- Providers may use Medicare appeals process
  - Slight differences include RAC discussion process and for inpatient PPS hospital appeals

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Extrapolation

- **All** claims of a provider can/will be reviewed for a particular issue
- Of those claims:
  - "Certainty" of error – Automated
  - High probability of error but not certainty – Complex
  - Record request limits (per 45 days)
  - Not permitted to target high dollar claims
- So what if high percentage of likelihood of error beyond record request limits?
  - Extrapolation

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Extrapolation

- Section 935 of MMA
- CMS empowers RACs to use extrapolation
- Can produce estimates of massive overpayments with minimal investment of contractor resources
- Must reach determination of a sustained or high degree of payment error

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Extrapolation

- Extrapolation must be reviewed and approved by the contractor consistent with Manual provisions.
  - Claims in an approved universe for extrapolation will be excluded from RAC review
  - Nebraska Outreach meeting: MAC will adjust the affected claims ultimately

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Appeal v. Recoupment

- Appealing a denial stays recoupment
- If unsuccessful on appeal, overpayment is subject to interest accruing from the date of the demand letter
- Interest rate adjusted quarterly (currently 11.125%)
- If no appeal, automatic recoupment
- Payment for current claims will be withheld until the full debt is satisfied or payment arrangements are made

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Appeals: Redetermination

- First level of appeal goes to the FI or MAC. (Discussion period is not an appeal)
  - 120 days to appeal, but only 30 days from date on letter (not receipt) to avoid recoupment
  - Recoupment begins on day 41 if no appeal has been filed
  - However, interest of approx. 11% must be paid if appeal is unsuccessful and recoupment was forestalled
  - MAC has 60 days to render decision
  - Demonstration project: redetermination was not very successful

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Appeals: Reconsideration

- Second level of appeal goes to the Qualified Independent Consultant (QIC).
  - 180 days to file this appeal, but only 60 days from date of decision on redetermination to avoid recoupment
  - Review on the record; no in-person meeting.
  - The record must be complete at this stage. No further opportunity to add to it on later levels of appeal.
  - QIC is bound by NCDs, CMS rulings and applicable law and regs; not bound by LCDs or LMRPs or CMS program guidance such as program memoranda and manual instructions.
  - All viable arguments should be made at this level.
  - QIC has 60 days to render decision; but may extend for 14 days if provider submits additional evidence

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Appeals: Administrative Law Judge (ALJ)

- Third level of appeal goes to the ALJ.
  - Amount in Controversy must be $120, but claims may be aggregated if on similar issues.
  - 60 days to file this appeal
  - An in-person meeting may be requested, but you must go to the ALJ's office or may use video teleconference if the technology is available.
  - ALJ has 90 days to act, or the provider may appeal to the Medicare Appeals Council.
  - ALJ is bound by NCDs, CMS rulings and applicable law and regs; not bound by LCDs or LMRPs or CMS program guidance such as program memoranda and manual instructions.
  - Demonstration Project providers reported this was the most successful level of appeal.

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Appeals: Medicare Appeals Council (MAC)

- Fourth level of appeal goes to the Medicare Appeals Council.
  - Amount in Controversy must be $120, but claims may be aggregated if on similar issues.
  - 60 days to file this appeal
  - MAC may decline review.
  - No in-person meeting.
  - MAC has 90 days to act.

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Appeals: Federal District Court

- Fifth level of appeal goes to Federal District Court.
  - Amount in Controversy must be $1220.
  - 60 days to file this appeal
  - Findings of fact by the Secretary of HHS are deemed conclusive

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Voluntary Refunds

- "If a provider voluntarily self-reports an overpayment ***after*** the RAC issues a demand letter or a request for medical record, the RAC will receive a discounted contingency fee."
- Self reports can go to MAC or RAC
- "RAC shall cease recovery efforts for the claims involved in the self-report immediately upon becoming aware"

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Voluntary Refunds

- If a provider voluntarily self-reports an overpayment, and the self-reported overpayment does **NOT** involve the same types of services for which the RAC had issued a demand letter or a request for medical records, then the RAC is NOT entitled to a contingency fee amount"
- RAC may continue recovery efforts since the overpayment the provider self-reported involved a different provider/service combination

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Voluntary Refunds

- "An Unsolicited/Voluntary refund is a refund that is submitted to the AC without a demand letter. It is a situation where the provider realizes that a refund is due the Medicare program and refunds the money to the AC. By definition, an unsolicited/voluntary refund (by check or by claims adjustment) must occur before a demand letter is issued. The RAC shall not receive any contingency payment on an unsolicited/voluntary refund."

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Self-Audit and Voluntary Refund

- What's the motivation?
  - Deprive RAC of its contingency fee
  - Determine repayment obligation based on published "new issues"
  - Don't wait for Medical Record Requests
  - Make repayments before the RAC begins its reviews
- What's the downside?
  - Uncertainty of standard
  - Self-audit might determine a higher repayment than the RAC would

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Self-Audit and Voluntary Refund

- Cottage industry of pre-RAC consulting
- Benefits from using RAC Consultant
  - Most claim experience from the Demonstration States
- Possible Negatives
  - Issues from Demonstration States are not all posted on the RAC websites
  - Consultants' issues might not match up with the new issues authorized for RACs

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False Claims Act Implications of Internal Audits

- FCA liability includes up to $11,000 per claim and treble damages ($ harm to government)
- Fraud Enforcement and Recovery Act of 2009; FCA liability for knowingly:
  - Presents a false or fraudulent claim for payment or approval
  - Makes/uses a false record or statement material to a false or fraudulent claim
  - "conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government"
- Health Care Reform: Failure to repay an overpayment within 60 days is a False Claim

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False Claims Act Implications of Internal Audits

- Obligation defined as an established duty arising from the retention of any overpayment.
- So when does a provider knowingly retain an overpayment?
  - What level of internal audit will give the provider knowledge of overpayments?
  - If there is a suspected error rate, is there an obligation to determine what it is and extrapolate for the entire period of the statute of limitations?
  - Which statute of limitations? Fraud (7 years) or cost report reopening for Part A providers (3-4 years)?

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CMS Recommendations

- Conduct internal assessment to ensure that submitted claims meet Medicare rules
- Identify where improper payments have been persistent by reviewing the RACs' websites and identifying any patterns of denied claims
- Implement procedures to promptly respond to RAC requests for medical records
- If provider disagrees with RAC determination, appeal within 120 day deadline
- Keep track of denied claims and correcting previous errors
- Determine what corrective action to ensure compliance and avoid future incorrect claims

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Compliance Strategies

- Identify and monitor areas that may be subject to review
  - OIG Work Plan
  - Demonstration Program
  - Notices published by RAC
  - RAC website

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Compliance Strategies

- Utilization review process critical
  - InterQual and Milliman USA criteria will be used by HDI
  - Some argument that criteria are not consistent with Medicare policy
  - Need to have process to involve physician reviewer

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Compliance Strategies

- Physician/Medical Staff Education
  - Good medical record documentation can be best defense
  - All RACs have stated they will go after related Part B claims following Part A denials
    - This did not occur in demonstration but will be part of permanent program
  - Open lines of communication between providers and UR staff during UR process

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