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RAC ATTACK: An Overview of the Recovery Audit Contractor Program

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Introduction

Just in case hospitals, skilled nursing facilities ("SNF") and physician practices were starting to get bored with their numerous and often cumbersome government compliance obligations, the Centers for Medicare and Medicaid Services ("CMS") has decided to expand the use of recovery audit contractors ("RACs"), private firms that audit the claims of providers that participate in fee-for service Medicare, including hospitals, SNF, physicians, durable medical equipment ("DME") suppliers and labs. Although previously a mere recommendation, it is now essential for the entities detailed above that may be subjected to RAC audits to incorporate RAC guidelines into their coding and billing compliance programs because RACs are here to stay, at least for now. The RAC program will soon have not only a financial but an operational impact on most health care institutions nationwide.

Undoubtedly contentious and controversial from its genesis, in March 2005, the RAC program began its three year demonstration phase where CMS hired RACs with the goal of reducing Medicare improper payments through: (1) efficient detection and collection of overpayments to providers; (2) identification and correction of underpayments to Medicare; and (3) implementation of actions to prevent future improper payments. During the demonstration phase, RACs received a negotiated contingency fee, equivalent to a percentage of the overpayments and underpayments they identified, in exchange for reviewing claims previously submitted to and paid by the government. Notably, this was the first time the Medicare program has paid a contractor on a contingency fee basis.[1]

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I. Timeline of RAC Program[2]

The development of the RAC program and its implementation are outlined below with reference to significant dates.

A. Demonstration Phase
- March 31, 2005: CMS announced the RAC initiative, not to last more than three years, and to be administered in at least two states with the highest per capita utilization of Medicare services;[3]
- March 1, 2006: RACs began to receive contingency fee compensation based on collected overpayments and underpayments;

B. Transition from Demonstration to Permanent RAC program:
- March 16, 2007: CMS released a Request for Information (RFI) which contained a draft statement of work for prospective permanent RAC contractors to review;
- August 16, 2007: CMS released a pre-solicitation notice which contained a statement of work;
- October 19, 2007: CMS released a Request for Proposal (RFP) which opened a question and answer period for prospective permanent contractors;
- November 7, 2007: CMS posted a revised Statement of Work.
- November 19, 2007: Answers to questions for prospective permanent contracts were posted;
- December 1, 2007: Last day demonstration RACs could issue medical records request letters to providers;
- February 1, 2008: Last day demonstration RACs could issue Part B demand letters;
- February 15, 2008: Last day demonstration RACs could issue Part A informational letters;
- March 31, 2008: Demonstration phase ended;
- Summer/Fall 2008: CMS to announce names of companies chosen to be permanent RACs in four regions and CMS and permanent RACs conduct extensive provider outreach;
- January 1, 2010: Implementation of the RAC program nationwide.

II. Legal Bases for the RAC Program

The RAC program is authorized by Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "Act"),[4] which directs the Secretary of the United States Department of Health and Human Services to conduct demonstration projects

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[1] CMS RAC Status Document FY 2007, *available at*:
http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf (July 13, 2008).
[2] RAC CMS homepage, *available at*: http://www.cms.hhs.gov/RAC (July 13, 2008).
[3] 42 U.S.C.A. § 1395(l)NOTE(b)(1); Demonstration Project for Coverage of Certain Prescription Drugs and Biologicals, Pub. L. 108-173, 117 Stat. 2321 (2003).
[4] 42 U.S.C.A. § 1395(l)NOTE; Pub. L. 108-173, 2003 HR 1.

through which select RACs worked to identify underpayments and overpayments, as well as recoup overpayments under the Medicare program associated with services for which payment is made under part A or B of title XVIII of the Social Security Act.[5]

The Act further specifies the methodology and procedures by which RACs may review certain provider claims.[6] For example, Section 935 of the Act states that RACs may not use random claim selection for any purpose other than to establish error rates applicable to their claim reviews.[7] RACs must also illustrate the specific data analyzed on claims that are most likely to contain overpayments.[8] Moreover, RACs are prohibited from reviewing claims solely because they are for large dollar amounts.[9] This seems logical given that during the demonstration phase, RACs were paid on a contingency fee basis. Lastly, RACs must be able to demonstrate the rationale for claim overpayment.[10]

The expansion of the RAC program is also derived from statutory guidance. Section 302 of the Tax Relief and Health Care Act of 2006 (the "Tax Relief Act") establishes the permanency of the RAC Program and requires expansion of the program to all fifty states by no later than January 1, 2010.[11] By 2010, CMS plans to have four RACs in place. Each RAC will be responsible for identifying overpayments and underpayments in approximately one-fourth of the country. The new RAC jurisdictions will match those of the DME Medicare Administrative Contractors ("MAC") jurisdictions.[12] Because the expansion of the program was addressed even before the end of the demonstration, the need for a report of recommendations to Congress, mandated by statute, was negated. Rather instead, an annual report to Congress is now required, which must include information on the performance of contractors and an evaluation of the comparative performance of such contractors.[13]

III.   Status of RAC Initiative

As of March 27, 2008, RACs corrected more than $1.03 billion in Medicare improper payments and providers chose to appeal 14% of the RAC determinations.[14] Of all the RAC overpayment determinations, only 4.6% were overturned on appeal.[15] Most overpayments (85%) were collected from inpatient hospital providers, 6% from inpatient rehabilitation facilities and 4% from outpatient hospital providers.[16] In February 2008, CMS published a RAC Status Report

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[5] *Id.*

[6] 42 U.S.C.A. § 1395ddd(f); Pub. L. 108-173, 2003 HR 1.

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] 42 U.S.C.A. § 1395ddd(f); Pub. L. 108-173, 2003 HR 1.

[11] 42 U.S.C.A. § 1395ddd(h)(3); Pub. L. 109-432,2006 HR 6111.

[12] See RAC CMS Home page for link to RAC Jurisdiction Map, *available at*:
http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf (July 13, 2008).

[13] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 4.

[14] *Id.* at 2. Approximately 96% of the improper payments were overpayments while the remaining 4% were underpayments.

[15] *Id.* CMS is currently unable to track all pending first-level appeals of RAC determinations, the dollar amounts returned to the Medicare Trust Funds are subject to change. *Id.*

[16] *Id.*

for the 2007 fiscal year ("Report").[17] The Report illustrated that RACs identified more than $300 million in improper payments during each of the three years of the demonstration phase, resulting in total recoveries of nearly $440 million from providers, mostly hospitals.[18] In its report released in July 2008, CMS updated this figure by stating, "even after subtracting the dollars in refunded underpayments, overpayment overturned on appeal, and RAC demonstration operating costs, the RACs returned approximately $693.6 million to the Medicare Trust Funds."[19] CMS believes it, "achieved a respectable return on investment of 318% in 2007," seeing that it, "spent only 22 cents for every dollar collected."[20] Most of the improper payments were attributed either to improper coding or to medical necessity criteria for the setting where a service was rendered. Other improper payments were related to outdated fee schedules or insufficient documentation to support the claim.[21] Interestingly enough, RACs discovered less than $10 million in underpayments to providers.[22] Identification of underpayments does not earn RACs significant compensation.

The cost to run the RAC demonstration was significantly less than the amount of recoveries.[23] The demonstration costs fall into three categories: (1) RAC contingency fees include the fees paid to RACs for detecting and collecting overpayments plus the fees paid for detecting and refunding underpayments; (2) Medicare claims processing contractor costs are the funds paid to the carriers, fiscal intermediaries ("FI"), and MACs for processing the overpayment/underpayment adjustments, handling appeals of RAC-initiated denials and other costs incurred to support the RAC demonstration; and (3) RAC evaluation, validation and oversight fees are the funds paid to various entities and individuals who oversee the RAC demonstration.[24] The cost data indicate that the RAC demonstration was a cost-effective program.

In order to determine providers' satisfaction with the RAC demonstration, CMS tasked the Gallup Organization to conduct phone interviews with a selected sample of 589 providers between May 2007 and July 2007.[25] The survey asked providers questions such as whether they felt CMS's efforts to recoup overpayments were fair and reasonable and whether they thought RACs would help ensure more accurate billing practices.[26] Notably, the same entity that

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[17] .See RAC CMS Home page for link to RAC Jurisdiction Map, *available at*:
http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf (July 13, 2008).
[18] *Id.*
[19] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 2.
[20] CMS RAC Status Document FY 2007, *supra* note 1.
[21] *Id.*
[22] *Prepare your practice for a visit from RACs*, Managed Care Contracting & Reimbursement Advisor. Vol. 5, No. 5, pg. 1-5, May, 2008.
[23] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 13.
[24] *Id.*
[25] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 2. The sample was randomly selected from over 4,200 providers who had received a medical record request or an overpayment recoupment from a RAC at least once in the 12 months before the survey date. *Id.*
[26] 74% of respondents found CMS's efforts to be reasonable and fair and 71% thought RAC reviews correctly applied Medicare policies.

administers the RAC initiative, CMS, also chose the organization to evaluate its progress and gather editorial feedback. To ensure the accuracy of the data obtained through the demonstration, CMS retained Econometrica, Inc. to audit the results.[27] While Econometrica, Inc. has reconciled the data for 2006 and 2007, it has not completed the reconciliation for 2008.[28]

RACs are intended to supplement, not replace, other review efforts by fiscal intermediaries, Program Safeguard Contractors, Benefit Integrity Support Centers, Quality Improvement Organizations and the United States Office of Inspector General. The RAC demonstration phase began in California, Florida and New York, states with the largest number of Medicare claims. Approximately 25% of Medicare payments are made each year to providers in these states.[29] Initially, each of the three RACs had one state as its jurisdiction. However, the jurisdictions were expanded in the summer of 2007 to include Arizona, Massachusetts and South Carolina.[30] Although it seems only a small number of states have been affected by the RAC program thus far, approximately twenty states have come under RAC scrutiny as the demonstration phase of the program has begun transitioning into the permanent phase.

However, there is a possibility that the scheduled nationwide implementation may be delayed if certain pending legislation is passed, namely, the Medicare Recovery Audit Program Moratorium of 2007[31] ("RAC Moratorium Law"), which was introduced into the U.S. House of Representatives on November 1, 2007 and seeks to impose a one year moratorium on the use of RACs. There are forty-five co-sponsors to this legislation and if enacted, it will postpone exposure and compliance costs for many healthcare provider. It is unclear if and how it could retroactively apply to claims review that occurred during the RAC demonstration phase. The RAC Moratorium Law seeks to suspend all further activities of the RAC program, including the execution of any new contracts for the permanent phase. Many supporters of the bill are providers who argue that RACs result in the denial of payment for legitimately provided services and cause providers to suffer enormous financial burdens which jeopardize their ability to care for patients. The bill was introduced by California Representative Lois Capps and his colleague Representative Devin Nunes, whose draft legislation would require CMS to submit a detailed report to Congress that: (i) examines all types of claims whether relating to overpayments or underpayments; (ii) reviews policies as they relate to the Medicare program as a whole; and (iii) evaluates the numerous flaws of the RAC initiative. For example, these Congressmen note that the California RAC, PRG Shultz, failed to routinely monitor provider impact before sending more medical record requests. Moreover, currently, an increasing number of RAC denials are being overturned on appeal in favor of the provider, which begs the question of whether the program is wasting perhaps as much taxpayer money as it is purportedly saving.[32]

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[27] The Medicare Recovery Audit Program: An Evaluation of the 3-Year Demonstration, June 2008 at 22.
[28] *Id.*
[29] During the initial portion of the demonstration phase the following RACs were utilized: California - PRG Schultz; Florida - Health Data Insights; New York - Connolly Consulting.
[30] *Id.*
[31] H.R. 4105, 110th Cong. (1st Sess. 2007).
[32] According to a CMS report issued February 28, 2008, RACs have uncovered $371.5 million in improper payments.

IV.   Qualification and Selection of RACs

Under the demonstration and permanent phases of the RAC program there are certain requirements that each RAC must meet. Specifically, RACs must have staff with the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the RAC must contract with another entity that has such knowledgeable and experienced staff.[33] RACs may not be FIs, carriers or MACs.[34] Additionally, in selecting RACs, CMS must give preference to entities that have demonstrated more than three years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program.[35]

CMS conducted a thorough and open competitive process to select the RACs for the demonstration, and in March 2005 awarded three contracts. The three contracts awarded were initially for the selected RACs to perform review in California, Florida and New York. However, in the summer of 2007, the jurisdictions were expanded to include Massachusetts, South Carolina and Arizona.   The selected RACs performed claim reviews during the demonstration for providers serviced by a FI or carrier in the RACs assigned state and for DME claims for beneficiaries who resided in the RACs assigned state. Specifically, the RACs selected were as follows[36]:

- California and Arizona[37]: PRG Schultz and its subcontractor, Concentra Preferred Systems
- Florida and South Carolina: HealthData Insights
- New York and Massachusetts: Connolly Consulting

In the spring of 2007, CMS began the process to procure four additional RAC contractors through a full and open competition. To this end and as reflected in the timeline above, CMS released a Request for Information which contained a draft statement of work and subsequently released a pre-solicitation notice which contained a revised statement of work. On October 19, 2007, CMS released a Request for Proposal which opened a question and answer period.   To date, CMS has not yet named the four additional RACs.

V.   RAC Claim Review Process

A. Scope of Claims Reviewed

Under the demonstration, CMS did not specify which claims the RACs were to review or even how the RACs were to identify claims for review.   However, the RACs were instructed to review claims submitted to Medicare by physicians, providers and suppliers; in order to detect

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[33] The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 306) (d)(1); Section 302 of the Tax Relief and Health Care Act of 2006 (h)(6)(A).

[34] Id. at (d)(2); Section 302 of the Tax Relief and Health Care Act of 2006 (h)(6)(B).

[35] Id. at (d)(3); Section 302 of the Tax Relief and Health Care Act of 2006 (h)(6)(C).

[36] MLN Matters Number SE0565

[37] While contractually Arizona was added to PRG's jurisdiction in FY 2007, no Arizona claims were reviewed in FY 2007 and no Arizona claims were reviewed before the end of the RAC demonstration.

Medicare improper payments[38] (including both underpayments and overpayments). RACs were charged with correcting such improper payments (i.e. by repaying money to a provider who was underpaid or collecting money from a provider who was overpaid). Improper payments[39] can occur under any of the following circumstances:

- Payments were made for services that were not medically necessary or did not meet the Medicare medical necessity criteria for the setting where the service was rendered;
- Payments were made for services that were incorrectly coded;
- Providers failed to submit documentation when requested, or failed to submit enough documentation to support the claim; or
- Other errors were made, such as the claim was paid using an outdated fee schedule, or the provider was paid twice because duplicate claims were submitted.

CMS left the claims selection methodology entirely up to the discretion of each individual RAC. Each RAC used the knowledge it had gained from prior experience auditing health care provider payments in the private sector and also used the findings of the Office of the Inspector General ("OIG") and the General Accounting Office reports to help target their reviews. Thus, one way providers can prepare for a RAC audit is by identifying high-risk and high-volume services likely to be targeted. Recovery of an overpayment to a provider by a RAC does not prohibit further investigation and/or prosecution, if appropriate, regarding allegations of fraud or abuse arising from such overpayment.[40]

B. RAC Review Process

CMS implemented the RAC review process because only a small percentage of claims (i.e. less than 5%) are examined during medical review of claims by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6% and 10% have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare.

Claims reviewed by RACs must have been submitted to the FI or carrier at least one year before the RACs' review in order to ensure that the ordinary processing has been completed. Under the permanent RAC program, audit and recovery activities may be conducted with respect to payments made under Medicare Part A or Part B within the applicable lookback period. RACs are guided by the same Medicare policies and rules to identify improper payments as the Medicare claims processing contractors and must apply national coverage polices and local coverage determinations that have been approved by the MACs.

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[38] The RAC program does not detect or correct payments for Medicare Advantage or the Medicare prescription drug benefit.

[39] The following claims were excluded from RAC review during the demonstration program: incorrect level of physician evaluation and management code; hospice and home health services; claims previously reviewed by another Medicare contractor; claims involved in a potential fraud investigation; and payments made to providers under a CMS conducted demonstration.

[40] Demo legislation at (e).

The RACs utilize two processes to identify improper payments: automated and complex. These two review processes are similar to those used by the Medicare claims processing contractors.

1. Automated Review

Automated review occurs when the RAC is able to make an overpayment or underpayment determination without evaluating the medical record associated with the claim. Such a determination is made by analyzing claims data using proprietary techniques to identify claims that clearly contain errors resulting in improper payments. For example, automated review can consist of a RAC using information systems to search for claims for two or more identical surgical procedures for the same beneficiary on the same day at the same hospital. The same surgical procedure is clearly not medically necessary, should not have been billed twice by the hospital, and therefore should not have been paid twice by the Medicare claims processing contractor.[41] RACs are not required to advise providers of the results of automated reviews unless an overpayment is found.

2. Complex Review

Complex review is when the RAC needs to review the medical record associated with the claim in question in order to make an overpayment or underpayment determination. RACs must have registered nurses or therapists make coverage and medical necessity determinations and have certified coders make coding determinations after review of the applicable medical record. An example of when a complex review is necessitated is when the RAC requests and reviews the medical record to verify that the diagnosis code listed on the claim matches the diagnosis described in the medical record. If the diagnosis does not match, the RAC then determines what the payment amount would have been if the claim had been coded correctly.[42] RACs are supposed to advise providers of the results of complex reviews within sixty days of a site review or receipt of medical records; however, a waiver of such requirement may be requested from CMS.

CMS may limit the number of medical records that RACs are permitted to request for complex review. Further, under the permanent program, RACs are required to pay for medical records associated with acute and long-term care hospital claims, but are not required to pay for those associated with other types of claims, including physicians. Providers have only forty-five days to respond to requests for medical records, although an extension may be obtained if requested within the forty-five day timeframe. Upon receipt of such records, the RAC has sixty days to complete its complex review and approve or deny a service.

3. Third-Party Review

In order to ensure that the RACs are making accurate claim determinations, in August 2007, CMS contracted with an independent third-party review entity, AdvanceMed, to serve as the RAC Validation Contractor ("RVC"). The RVC was tasked with the goals of reviewing a

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[41] CMS RAC Status Document FY 2007, *supra* note 1 at 15.
[42] *Id*. at 16.

small number of claims that represented new issues for which the RAC wished to begin full-scale review and reviewing a random sample of overpayment claims from each RAC. Based on the RVCs findings, CMS may choose to implement changes to the permanent RAC program. AdvanceMed's role as the RVC differs from Econometrica's in that AdvanceMed's review is considered independent.[43]

C. Appeal Process

The statutory framework for the RAC initiative contemplates the utilization of administrative remedies prior to judicial review. From the inception of the RAC program through March 27, 2008, providers appealed approximately 14% of the RAC determinations and only approximately 5% of such appeals were overturned.[44] The RAC appeals process is virtually the same as the Medicare standard appeals process, with one difference being that at the outset of the RAC appeals process the provider may choose to submit a rebuttal to the RAC prior to appealing to the FI for a redetermination. Such rebuttals must be requested by the provider within fifteen days of receiving a notice of a claim denial from the RAC. The RAC has sixty (60) days to respond to the rebuttal; however, the RAC may contact its project officer for a time extension. To date, providers have reported limited success with rebuttals for denials of inpatient stays based on medical necessity, particularly one-day stay denials.[45]

In the event the provider's rebuttal is denied, there are five levels of appeal the provider may choose to undergo, namely:[46]

1. Redetermination through the provider's FI;[47]

2. Reconsideration through a Qualified Independent Contractor ("QIC");[48]

3. Hearing before an Administrative Law Judge ("ALJ") at the Office of Medicare Appeals ("OMHA");[49]

4. Review by the Department of Health & Human Services ("DHHS") Medicare Appeals Counsel.[50] The provider does not have a right to seek MAC review if the ALJ at the prior appeal level remanded the appeal to the QIC or affirmed the QIC's dismissal of a request for reconsideration; and

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[43] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 22.

[44] *Id*. at 20.

[45] Healthcare Compliance Quarterly Insights: Surviving RAC.

[46] The Provider Reimbursement Review Board ("PRRB") is body that conducts certain Medicare appeals; however, it is not part of the RAC appeal process. Rather, it is an independent panel for certain appeals and its review is limited to issues of cost reasonableness and disputed reimbursement amounts due a provider for admittedly covered services.

[47] 42 C.F.R. 405.940 et. seq.

[48] 42 C.F.R. 405.960 et. seq.

[49] 42 C.F.R. 405.1000 et. seq. As of May 1, 2008 CMS estimates there are an additional 3,009 claims (valued at $25.3 million) pending at the QIC and ALJ levels of appeal.

[50] 42 CFR 405.1100 et. seq.

5.   Judicial Review in a United States Federal court. For 2008, the provider's appeal must include an amount in controversy of at least $1,180 in order to enter a United States Federal court.

In addition to navigating the appellate process, some providers may consider an alternative method to recoup certain funds by determining whether a denied claim could be paid by other third-party payers. Overall, in order to craft the most effective and efficient action plan, providers must review and discuss the substance and status of their current pending claims, all of which must be timely perfected in the appellate processes.

VI.   Permanent Phase v. Demonstration Phase

As discussed above, the Tax Relief Act requires CMS to expand the RAC program and make it permanent by January 1, 2010. CMS has relied on information obtained during the demonstration phase to improve the permanent phase. The permanent program reflects changes in the process and the requirements for RACs.

A.   Changes in Procedure

While the look back period was four years during the demonstration phase, it will be three years during the permanent program.[51] Moreover, during the permanent program, the RACs will not be able to look for any improper payments made prior to October 1, 2007.[52] However, during the demonstration phase, there was no maximum look back date.[53] The look back limit of October 1, 2007 is a positive change for providers because "even providers that have not yet implemented Medicare coding and billing compliance programs have limited exposure."[54] Although the three year limit will not be relevant until October 1, 2010, it is a boon for providers, as it protects them from an additional year of potential liability.

During the demonstration phase, RACs were prohibited from reviewing claims from the current fiscal year; however, they will be allowed to do so during the permanent program.[55] During demonstration, external validation was optional, but it will be mandatory for the permanent phase.[56] Therefore, in order to ensure that RACs make accurate claim determinations, CMS will work with the selected RVC.[57] The RVC may review certain claims that represent new issues for which a RAC wishes to begin a full-scale review.[58] The RVC may also review a random sample of overpayment claims from RACs.[59] The purpose of an external validation is to ensure the accuracy of RAC findings.[60]

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[51] CMS RAC Status Document, FY 2007 at 4.
[52] Id at 5.
[53] Id.
[54] *Prepare your practice for a visit from RACs,* Managed Care Contracting & Reimbursement Advisor, May 2008, Vol. 5, No. 5 at 2 (quoting David C. Harlow, Esq., principal at The Harlow Group, LLC).
[55] CMS RAC Status Document at 5.
[56] Id.
[57] CMS Status Document at 19.
[58] Id.
[59] Id.
[60] Id.

Another difference between the two phases of the RAC initiative is that during the demonstration, there were limited reporting requirements for problems discovered by RACs. However, in the permanent phase, reporting will be required. In the demonstration phase, each RAC could set its own limit on the number of records it could request from a provider. CMS, however, will limit the number of medical records that a RAC may request during the permanent phase. The limit will be based on a sliding scale such that the limit will be higher for larger facilities and lower for smaller ones.[61] Because record production was so onerous for providers during the demonstration phase, the implementation of a limit was an achievement for providers.

During the demonstration phase, if a provider requested to speak with the medical director regarding a claim denial, it was optional; however, during the permanent phase, it is mandatory. The appeals process has also been modified for the permanent phase. During the demonstration phase, RACs had to return the contingency if they lost at the first level of appeal. In the permanent phase, recoupment is deferred during the first two levels of appeal.[62]

B.   Changes Affecting RACs

During the demonstration phase, it was not necessary that RACs employed certified coders experts or a medical director. However, in the permanent phase, RACs must employ a medical director and certified coding experts. This change benefits providers who argued during the demonstration phase that RAC employees did not have experience in Medicare coding. In the permanent program, all RACs must have a web-based program by January 1, 2010 to allow providers to update their contact information and monitor medical record requests and the receipt of records by RACs.[63] This improvement came at the request of the American Hospital Association, the California Hospital Association and the Healthcare Association of New York State.[64]

VII.   Advice for Providers

Given that the RAC program will be fully implemented across the United States by January 1, 2010 and that many states will begin implementing the program in the fall of 2008 or January 2009, providers need to start preparing now. Although RACs will likely first go after providers with large Medicare claims, including hospitals and SNFs, all providers must equip themselves for compliance with audit and record requests.[65] RAC audits and investigations often prove to be burdensome, time-intensive and costly for providers. Providers should prepare for the arrival of RACs by taking the following important steps:

A.   Evaluate

A provider should first review the most recent CMS RAC Status Report, currently from fiscal year 2007, to familiarize itself with the fundamentals of the recovery audit program. A

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[61] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration at 26.

[62] MMA s935a (see also CMS transmittal 314 to Pub. 100-20, 2/1/08).

[63] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration at 26.

[64] AHA letter to House of Representatives, December 10, 2007 *available at* http://www.aha.org/aha/letter/2007/071211-let-racs.pdf (July 13, 2008).

[65] Prepare Your Practice at 2.

hospital's general counsel or compliance officer may be the best person to first evaluate this information. In a physician practice setting, this responsibility may rest with the office manager. In addition to examining the Report, such persons should familiarize themselves with the information available on the CMS website, including the state roll-out dates to determine when the program will be implemented in the provider's state. This knowledge will allow a provider to manage and focus its preparation within the time available to it.

After evaluating the information available on RACs, the person who has studied this material ("Program Initiator"), should review the provider's compliance policies and plans, if any, and billing and coding policies and procedures. The Program Initiator should also gather some basic information about the provider's coding software and process. For example, the Program Initiator should reach out to the provider's coder or health information technology specialist to obtain information about the quality of the coding software utilized by the provider.

B.   Educate and Create a RAC Team

The Program Initiator should educate the provider's leadership, including those who make the day-to-day decisions for the provider, regarding the intricacies of the RAC program. Legal counsel, compliance officers or any compliance committee should be educated about the RAC program and the ability of the provider's policies and plans to withstand a RAC invasion, if they have not already been informed.

The provider should form a RAC team. The Response Initiator may head up this team or it may be led by someone whom the leadership determines is more qualified. The team should consist of individuals who will assess and strengthen the current policies and procedures, as may be necessary, and respond to RAC requests. The size and structure of the team may vary depending on the provider's resources, preparedness and size. For example, the team may consist of a small number of individuals for private practice groups and a larger number of individuals for a hospital system. Further, the team may consist of information technology specialists, compliance professionals, finance specialists, legal counsel, medical and nursing staff and other consultants. The provider should identify a point person on the RAC team who will lead the team, convene the team, as well as receive and lead the effort in responses to RAC communications; the providers' staff and the RAC team should be trained to refer all communications with RACs to this point person. The RAC team may assist in developing the process for the provider to follow when a RAC request for records or demand letter is received. Once the process has been determined, the RAC team should be trained on this process. The process should include a tracking component to accurately track dates when records are requested, produced, and when other correspondence or action is taken, including the filing of appeals. The RAC process involves deadlines and time limitations and it is important that these time limitations are honored. The RAC team may encourage the board to maintain capital reserves for RAC demands and other compliance needs.

C.   Examine

Once the provider's RAC team has been assembled, the team should examine the provider's compliance policies, plans and procedures. If a compliance plan is not in place, the implementation of RACs is all the more reason to create one. "The focus of the RAC program is

to reverse improper payments based on coding and billing errors. The best way to eliminate such errors is to follow the OIG model compliance plan and to track the entire life cycle of [the provider's] billing and collections system."[66] A strong compliance plan will outline policies and procedures to ensure that services are coded accurately and billed to the right payor.[67] Moreover, providers must ensure that coders are properly trained and that personnel are educated about coding and medical necessity rules so that incorrect claims are not submitted, thereby resulting in incorrect payments.[68] Staff members must be also informed of any changes that affect coding.[69]

The team should also assess the record management system. Is the system complete and easy to locate? Are the records on-site or off-site? The team should decide who will be responsible for copying requested records for RACs. Will it be internal staff and employees or should the provider hire an external vendor? It is critical that the provider has assessed the record management system and has a process in place for copying records because records not sent to a RAC in a timely basis will result in an automatic finding of an overpayment.

If the RAC team or Response Initiator determines that the provider's coding analysis software program is not satisfactory, the RAC team should investigate and install new software.

D.   Focus on Problem Areas from Demonstration Phase

Depending on the amount of time and resources available to a provider, a provider may desire to focus its preparation and compliance efforts on areas which were repeatedly identified as problematic during the demonstration phase. For example, most overpayments uncovered by RACs during the demonstration phase were to inpatient hospitals. "Because RACs are paid on a contingency fee basis, they establish their claim review strategies to focus on high dollar improper payments, like inpatient hospital claims which give them the highest return with regard to the expense of reviewing the claim and/or medical record."[70] The demonstration phase also revealed that most improper payments result when providers submit claims that do not comply with coding or medical necessity policies.[71] Approximately 9% of uncovered overpayments during the demonstration phase resulted from insufficient or no documentation. This occurs when, "a RAC requested a medical record from the provider, and the provider either failed to respond within the appropriate time limits or failed to send the complete medical records."[72] Providers may choose to focus on coding and medical necessity. Additionally, they may focus on more specific vulnerabilities identified by RACs during 2007. For example, with respect to inpatient hospital services, RACs found that services resulting in the most overpayments to providers were excisional debridement, in-patient rehabilitation facility services following joint replacement surgery, heart failure and shock, surgical procedures in wrong setting, respiratory system diagnosis with ventilator support and extensive operating room procedures unrelated to the principal diagnosis.[73] Colonoscopies, speech language pathology services and infusion

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[66] Prepare your Practice at 4.
[67] *Id.* at 5.
[68] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration at 27.
[69] *Id.*
[70] CMS RAC Status Document FY 2007 at 12.
[71] *Id.* at 13.
[72] *Id.*
[73] *Id.* at 18.

resulted in the most overpayments with respect to outpatient hospitals, and pharmaceutical injectables, duplicate claims and vestibular function tests resulted in the most overpayments to physician practices.[74]

E.   Responding to Demand Letters

In the event that a provider is confronted with a demand letter, the RAC team should familiarize itself with the provider's practices in addressing government audits and overpayment claims. The team should also explore the compliance implications of the RAC's findings and develop a defense strategy with legal counsel. The provider should perform its own audit of the RAC overpayment schedules to determine the reason for the overpayments and to confirm the amount of the alleged overpayment. If underpayments were calculated, a provider may wish to perform internal audits to determine whether there were additional underpayments which the RACs failed to uncover.

F.   Self-Audit

Effectuating a RAC appeal undoubtedly necessitates the allocation of substantial time and resources. Therefore, it is not recommended that providers appeal each claim separately. Instead, it may be possible to informally request government agency cooperation to consolidate various types of claims based on common substantive issues (e.g. Medicare procedures, Medicare definitions, quality improvement organization guidelines, exigent circumstances, etc.). In conjunction with the task of grouping similar substantive claims, it is necessary to classify and distinguish claims where certain defenses to overpayment may apply. Providers should conduct their own internal audits to determine which codes and services require correction. Internal audits may be conduced by provider personnel or with the help of an outside consultant.

G.   Litigation Alternatives

The major obstacle for providers adversely affected by the RAC program is utilizing judicial techniques. Congress provided for administrative and judicial review of determinations of coverage and payment in the Medicare program. However, judicial review can only be sought after exhaustion of administrative remedies.

Although there has been no precedent establishing injunctive relief as a viable solution in this context, it could arguably become one. These audits involve unique health care entities that, unlike other corporate organizations, provide health care services affecting public welfare. As a result, there is a strong basis for a court to consider temporary injunctive relief. Such relief might mandate cessation of further RAC audits and recoupments until existing claims of a provider are addressed and resolved so as to enable a provider or health care entity to function properly and continue to administer health care services.[75] Additionally, there has yet to be an instance where a class action has been pursued by multiple providers to rebut similar claims of overpayment. Moreover, providers could consider joining together in pursuing a declaratory

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[74] *Id.*

[75] Nationwide, many health care entities have recently been forced into bankruptcy due to the "credit crunch," as many providers rely on certain financing affected by this crisis. This reality could aid in supporting an argument for injunctive relief to prevent further hospital closings and to preserve continuous and quality patient care.

judgment action. This type of judgment occurs in a civil case where a court tells the parties what their rights and responsibilities are, without awarding damages or ordering them to do anything. Courts are usually reluctant to hear declaratory judgment cases, preferring to wait until there has been a measurable loss. However, in this instance, there has already been millions of dollars of measurable loss to many providers.

VII.   Conclusion

With increasing expenditures, expanding Federal benefits and a growing beneficiary population, the importance and challenges of safeguarding the Medicare program are greater than ever.[76] As providers prepare for the permanent phase of the RAC program, it is imperative that they adhere to a stringent plan relating to correspondence and requests from RACs and CMS. An internal team must log each demand letter or request for medical records into a tracking system. Further, it must verify which claims are open for a RAC to review and classify each demand by issue type and monetary impact. The team should meet regularly to review new demands and status of prior demands while simultaneously prioritizing review of claims by time remaining for responses. If the volume of requests and demands is determined to be excessively burdensome, providers may consider making a formal request for extension by the RAC, notify CMS and inform the local hospital association.

"CMS views the RAC program as an adjunct to its present program and a new valuable tool for helping prevent future overpayments."[77] Admittedly, this initiative has yielded some positive results. However, it remains to be seen whether the millions of dollars of recoupments outweighs the burdens that have adversely affected administrative and clinical resources of hospitals and other health care entities across the nation.

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[76] The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration; CMS Press Release; July 11, 2008; page 6.
[77] CMS RAC Status Document FY 2007, *supra* 1.