

**THE RECOVERY AUDIT CONTRACTOR (“RAC”) PROGRAM:
What Can Laboratories and Pathologists Expect?**

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The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program is now operational nationwide. Laboratories and pathologists should begin to prepare now for increased auditing activity. Should a provider be faced with a RAC denial and overpayment demand, such a determination can be appealed. This article will outline the fundamentals of the RAC program, and will set forth key issues of which all providers should be aware to challenge RAC denials.

RECOVERY AUDIT CONTRACTORS... The Beginning

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), directed the Department of Health and Human Services (HHS) to initiate a three-year demonstration program using RACs. The demonstration began in 2005 in the three states with the highest Medicare expenditures: California, Florida and New York. In 2007, the demonstration expanded to include Massachusetts, South Carolina and Arizona. The purpose of the RAC demonstration program was to determine whether the use of RACs would be a cost-effective way to identify and correct improper payments in the Medicare program.

The RAC demonstration program proved highly “cost effective.” Over the three-year demonstration, the RACs identified more than \$1.03 billion in improper payments. The vast majority of this amount, 96 percent, constituted alleged overpayments. CMS estimates that the

RAC demonstration program cost approximately 20 cents for each dollar returned to the Medicare Trust Funds.¹

RECOVERY AUDIT CONTRACTORS... The Expansion

Section 302 of the Tax Relief and Health Care Act of 2006 made the Medicare RAC program permanent and required its expansion nationwide by no later than 2010. CMS divided the nation into four regions and assigned a Medicare RAC contractor to each:

- Diversified Collection Services, Inc. is the RAC for Region A, comprised of the Northeastern states;
- CGI Technologies and Solutions, Inc. is the RAC for Region B, comprised of the Midwestern states;
- Connolly Consulting Associates, Inc. is the RAC for Region C, comprised of the Southern states; and
- HealthDataInsights, Inc. is the RAC for Region D, comprised of the Western states.²

RECOVERY AUDIT CONTRACTORS... The Future

In addition to the existing Medicare RAC program, which applies to Medicare Parts A and B, Section 6411 of the Patient Protection and Affordable Care Act (“Affordable Care Act”) requires the RAC program to expand to Medicare Advantage claims (Part C), Medicare Prescription Drug claims (Part D), and Medicaid claims.³ As the rules associated with this expansion are not yet finalized, this article will focus upon the existing Medicare RAC program.

¹ The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 15, June 2008, available at http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf. This report was updated as CMS compiled additional appeals data. Updated reports are available at www.cms.hhs.gov/RAC.

² *Id.* Note that the RAC Expansion Schedule, available at <https://www.cms.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>, identifies the four RAC regions, labeled A, B, C and D.

³ See Medicaid RAC Proposed Rule, available at 75 Fed. Reg. 69037 *et seq.* (November 10, 2010); see also Medicare Parts C and D Proposed Rule, available at 75 Fed. Reg. 81278 *et seq.* (December 27, 2010).

RECOVERY AUDIT CONTRACTORS... The Review Process

CMS compensates RACs on a contingency fee basis, based upon the principal amount collected from (or the amount repaid to) a provider or supplier.⁴ The contingency fee percentages range from 9 to 12.5 percent.⁵ Because of this compensation arrangement, the RACs are highly incentivized to find improper payments upon review.

The RACs may attempt to identify improper payments resulting from:

- Incorrect payments;
- Non-covered services (including services that are not reasonable and necessary);
- Incorrectly coded services; and
- Duplicate claims.⁶

The RACs have broad discretion in determining which claims to review, however certain limitations are in place. For example, RACs may not may review claims at random. They must use “data analysis techniques” to identify claims likely to be overpayments, a process called “targeted review.” Additionally, the RACs may only review claims paid on or after October 1, 2007. As time passes, the RACs will be prohibited from reviewing claims more than three years past the date of initial determination.⁷

TYPES OF REVIEWS

RACs engage in two types of claim reviews to identify improper payments: “automated review” and “complex review:”

⁴ RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage.

⁵ See https://www.fbo.gov/index?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&_cview=1&cck=1&au=&ck=

⁶ RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage.

⁷ *Id.*

An “automated review” is a review of claims data without a review of the records supporting the claim. Generally speaking, RACs may conduct automated reviews only in situations where there exists both (a) a certainty that the service is not covered or is incorrectly coded, and (b) a written Medicare policy, article, or coding guideline applicable to the claim. RACs also may use automated review, even if there is no specific Medicare guidance on point, in “clinically unbelievable” situations or when identifying duplicate claims and/or pricing mistakes.⁸

A “complex review” consists of a review of medical or other records, and is used in situations where there is not certainty that a claim involves an overpayment.⁹ In summary, the RAC “complex review” process is as follows:

- RACs are authorized to: (a) visit a provider’s location to view and/or copy medical records, or (b) request that such records be securely transmitted to the RAC for review.¹⁰ The RAC websites contain detailed guidelines for records submission.¹¹ Importantly, requested records must be returned within 45 days. It is imperative that providers timely respond to RACs’ requests for medical records. If a RAC does not receive requested medical records within 45 days, it is authorized to render an overpayment determination. Providers failing to timely respond to RACs’ medical records requests could lose appeal rights with respect to these claims.¹²
- In conducting reviews, RACs are required to comply with National Coverage Decisions (“NCDs”), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, Local Coverage Decisions (“LCDs”), and local coverage and

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ <http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf>. Additionally, CMS has placed limits on the number of records a RAC may request from a given provider per 45-day period. These limitations are published on the CMS RAC website, available at http://www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage.

¹² According to the RAC Statement of Work, if a provider appeals this type of claim denial, RAC Statement of Work, “the appeals department **may, at CMS direction**, send the claim to the RAC for reopening under certain conditions...” (emphasis in original). However, the Carrier or Intermediary **is not required** to send the claim to the RAC for reopening. See RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage.

coding articles.¹³ The RACs also are authorized to develop internal guidelines to assist their reviewers to conduct claims reviews.¹⁴

- Generally speaking, a RAC must complete complex reviews within 60 days from receipt of the requested medical records.¹⁵ Following its review, the RAC will issue a letter to the provider setting forth the findings for each claim.¹⁶ The claim will be adjusted on a RA, and a demand letter will be issued.
- Alleged overpayments identified by the Medicare Part A/B RACs may be appealed through the Medicare appeals process.

HOW SHOULD PROVIDERS PREPARE FOR A RAC AUDIT?

Although providers cannot prevent RAC audits from happening, they can prepare for increased claims scrutiny and RAC activity. It is advised that providers assign an audit point person, responsible for the following tasks:

- Regularly monitoring guidance documents educating providers regarding the types of claims subject to RAC reviews, including: the RACs' websites and guidance documents such as the OIG Work Plan (Note that, to date, the RACs have approved the numerous issues for review impacting both hospital-based and office-based providers.¹⁷ The OIG Work Plan for 2011 includes laboratory test unbundling by clinical laboratories as well as general trends in laboratory utilization as issues that will be monitored and potentially audited during FY 2011¹⁸);
- Implementing compliance efforts targeted towards compliance risk areas;
- Responding to record requests within the required timeframes; and
- Monitoring appeals deadlines and properly working up appeals to challenge denials in the appeals process.

¹³ RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Links to the Recovery Audit Contractor websites, with listed approved issues, are available from the CMS RAC website: <http://www.cms.hhs.gov/RAC>.

¹⁸ The 2011 OIG Work Plan is available at <http://oig.hhs.gov/publications/workplan/2011/>.

HOW TO APPEAL CLAIM DENIALS MADE BY RACS

Before engaging in the Medicare appeals process, providers subject to a RAC denial may wish to engage in a “discussion period” with the RAC. According to CMS:

The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period. You always contact the RAC for this option. The timeframe is between day 1 and 40 and will begin with receipt of the demand letter for automated review and from receipt of the review results letter for complex review. The timeframe ends on day 40.¹⁹

If the discussion period does not prove effective, Medicare Part A/B RAC denials may be appealed the standard Medicare appeals process set forth in 42 C.F.R. Part 405:

- Stage 1: Redetermination. The first level in the appeals process is redetermination. There is no amount in controversy requirement. Providers must submit redetermination requests in writing within 120 calendar days of receiving notice of initial determination.
- Stage 2: Reconsideration. Providers dissatisfied with a redetermination decision may file a request for reconsideration to be conducted by a Qualified Independent Contractor (QIC). There is no amount in controversy requirement. This second level of appeal must be filed within 180 calendar days of receiving notice of the redetermination decision.

Significantly, providers must submit a “full and early presentation of evidence” in the reconsideration stage. When filing a reconsideration request, a provider must present evidence and allegations related to the dispute and explain the reasons for the disagreement with the initial determination and redetermination. Absent good cause, failure of a provider to submit evidence prior to the issuance of the notice of reconsideration precludes subsequent consideration of the evidence. Accordingly, providers may be prohibited from introducing evidence in later stages of the appeals process if such evidence was not presented at the reconsideration stage.

- Stage 3: Administrative Law Judge (ALJ) Hearing. A provider dissatisfied with a reconsideration decision may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC’s decision and must meet the amount in controversy requirement.

¹⁹ See https://questions.cms.hhs.gov/app/answers/detail/a_id/9994/~/_/what-is-the-difference-between-the-rac-discussion-period-and-the-rebuttal-and

- Stage 4: Medicare Appeals Council Review. The fourth level of appeal is the Medicare Appeals Council (MAC) Review. A MAC Review request must be filed within 60 days following receipt of the ALJ's decision.

Among other requirements, a request for MAC Review must identify and explain the parts of the ALJ action with which the party disagrees. Unless the request is from an unrepresented beneficiary, the MAC will limit its review to the issues raised in the written request for review.

- Stage 5: Federal District Court. The final step in the appeals process is judicial review in federal district court. A request for review in district court must be filed within 60 days of receipt of the MAC's decision and meet the amount in controversy requirement.

STRATEGIES FOR APPEALING CLAIM DENIALS

Once a provider receives a claim denial made by a RAC, it is important that the provider aggressively pursue appealing the denial through the Medicare appeals process. Experienced healthcare legal counsel can assist providers with appeals to ensure all available substantive challenges and legal theories are utilized. Experienced counsel will submit an appeal brief/position statement that advocates the provider's position and raises applicable legal challenges, which may include the legal theories of: waiver of liability, provider without fault, and challenges to any statistical extrapolation.

CONCLUSION

Providers should be ready for increased Medicare auditing activity. Providers should act now to get systems in place to prepare for RAC records requests and possible claim denials and to evaluate their compliance with Medicare guidelines. Should a provider be subject to RAC denials, effective strategies are available that can be successfully employed in the appeals process.



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