



PRACTICE MANAGEMENT

Putting Practices on the RAC

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Recovery Audit Contractors (RAC) are yet another group of people dispatched by the Centers for Medicare and Medicaid Services (CMS) to look for, and most likely find, overpayments to physicians. Since they are paid a contingency fee for locating discrepancies, they are quickly becoming [viewed as bounty hunters by many practices](#).

“RACs are tasked by CMS to go out and find overpayments and underpayments for Medicare services,” said Abby Pendleton, Esq., from The Health Law Partners, PC, in Southfield, Mich. “The reality is that they are really out there looking for overpayments. Their percentage of any recovery runs between 9% and 12%.”

There are currently four RACs working in the United States. RACs review claims on a post-payment basis. They are supposed to use the same Medicare policies as Carriers, Fiscal Intermediaries, and similar Medicare programs and follow the CMS manuals.

Unlike other types of auditing, these contractors can only look at specific issues approved by CMS prior to the review. Although many of these will probably be the same from contractor to contractor, others may be suggested by the RAC subject to CMS approval.

Currently, the look-back period is three years. CMS also limits the number of medical records that can be demanded, based on the number of physicians in a given practice.

If RACs find a concern, they can use statistics to extrapolate how much money should be returned to Medicare. This is not always based on chart audits.

“Contractors are not required to show everything you have done wrong,” said Jeffery Ward, MD, Clinical Practice Committee chair for the American Society of Clinical Oncology. “For example, if they audit a sample of 10 charts out of 1,000 a practice submitted for a specific code and they think two of them are wrong, they will ask for repayment for 200 patients.”

This means that all practices should take audits very seriously.

“I don’t think there is any question that a RAC audit has the potential to destroy a practice financially,” Ward noted. “These audits can very easily turn into big dollar losses and decimate a practice.”

The next question becomes what can a practice do to avoid being audited? Apparently there is very little.

“We are often asked what can someone do to avoid audits,” said Jessica Gustafson, Esq., also with Health Law Partners. “I believe that it isn’t a matter of if, but rather when, an audit takes place.”

For RAC audits, and most others, the best defense is a good charting. Since every RAC gets specific marching orders from CMS, it is also suggested that practices contact their contractor to see what they can review and concentrate on those issues.

“Physicians in particular have to pay special attention to enhancing their documentation knowing that at some time it will be reviewed by someone,” Pendleton said. “Include information on medical necessity so when an auditor comes in it is very apparent to someone who doesn’t know the patient why something was done.”

Ward notes that having a good rationale for a treatment or intervention may not always be enough. He points to a controversy oncologists are having when RACs deny payment for using Neulasta (pefilgramstim).

“When the medication was approved 10 years ago, the label said it should not be given any time two weeks before chemotherapy or until 24 hours after chemotherapy,” said Ward. “In the interim we have developed ‘dose dense’ regimens giving chemotherapy at two-week intervals. The literature shows Neulasta can safely be given on the day of chemotherapy, and many use it in that manner when next-day therapy is a hardship for the patient.”

However, RACs are denying claims and asking for paybacks because this is outside of the parameters of the label.

“The money is not being demanded because the medication was inappropriate to give or it did not benefit the patient,” Ward stressed. “Physicians did not follow the strict label that may have been approved years ago; so the RACs are denying claims simply because they can.”

Medications can be very fertile ground for RACs. Many medicines are approved for one thing initially; however, as oncologists gain more experience with them, more uses become clinically acceptable and even part of standards of care. Unfortunately, RACs may not see things the physician’s way without studies supporting the use.

If you are audited and claims are denied, all the experts agree there is very little to lose and quite a bit to gain by appealing. Pendleton notes that documentation from the CMS suggests that over 60%

of all appeals are found in the provider's favor. These figures are probably conservative since CMS publishes figures on a fiscal year basis and it can take over a year to exhaust appeals.

"Our experience indicates the success rate could run to 90% or more," she said. "If you are confident the service you provided was appropriate, you should appeal because you have a reasonable likelihood of winning."

If a practice is audited and payments are denied, there is a very stringent protocol and timeline for appeal. Should one be missed, the appeal dies. Because of this, it is suggested that practices designate a person responsible for assembling records for the initial audit and keeping track of all deadlines for appeals.

"The reality of the situation is that the physician community is under a lot of pressure from auditors and it not just RACs," Gustafson said. "In addition to other players under Medicare, we are seeing significant increases in audits by private payers. Practices need to acknowledge this and establish protocols for addressing these issues from initial documentation through to the last appeal."