

# Recovery Audit Contractors

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MEDICARE

February 26, 2009

Certified Mail  
Return Receipt Requested  
7004 2510 0002 1418 8366



Dear [Redacted]

This is to let you know that you have received Medicare payment in error which has resulted in an overpayment to you of **\$226,473.77** for services listed in the Overpayment Summaries. The following explains how this happened.

We have completed our **Statistical Sampling Medical Review** of the **April 1, 2006**, through **March 31, 2007**, medical record information you sent to us in response to our request. Our determination is provided below.

**HOW THIS OVERPAYMENT WAS DETERMINED:**

We have determined that the Medicare Part B Program overextended its liability to you in the amount of **\$226,473.77** and a refund in that amount is now being requested. A refund is being requested based on a sample of claims reviewed. The Statistical Sampling Medical Review Educational Summary and a patient listing for each sample case are enclosed along with a breakdown of the services at issue. If the patient has paid you more than the amount noted in the "Patient Liability" column on the attached document, please contact them to settle this account.

**WHY YOU ARE RESPONSIBLE:**

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. In this situation you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount. If you dispute this determination please follow the appropriate appeals process listed below. (Applicable Authorities: Section 1870 (b) of the Social Security Act; Sections 405.350-405.359 of Title 42, Sections 404.506-404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations).



901 40<sup>th</sup> Street South – Suite 1  
Fargo ND 58103

# Medicare

Redetermination Department  
P.O. Box 6711  
Fargo, ND 58108-6711

**FRAN ALLERY CPC  
REDTERMINATION OFFICER**

**PHONE (701) 277-2148  
FAX (701) 277-6520**

*December 31, 2007*



***This is your MEDICARE PART B Redetermination Officer REDETERMINATION DECISION.***

**CASE CCN:**   
**AR#:**

***RE: See Attached List of Beneficiaries, Health Insurance Claim Numbers, Internal Control Numbers and Dates of Service  
TYPE OF SERVICE: Reduction of Injection of Neurolytic Substance (62282) to Injection of Diagnostic or Therapeutic Substance (62311)  
DATE(S) OF SERVICE: January 1, 2003, through September 20, 2006  
PROVIDER/SUPPLIER:   
OVERPAYMENT: \$68,955.51***

***This decision is UNFAVORABLE. Please refer to the last two pages of this decision regarding further appeal rights.***

***Dear Ms.***

***This is a new and independent decision on your Medicare Part B redetermination request. A redetermination is a new and independent review of claims. You are receiving this decision because you filed a redetermination request regarding an overpayment of \$68,955.51 covering the reduction of Injection of Neurolytic***



Rec'd in mail  
9-11-08  
1pm



**DEPARTMENT OF THE TREASURY  
FINANCIAL MANAGEMENT SERVICE  
BIRMINGHAM, AL 35283-0794**

September 6, 2008

[Redacted]

FedDebt Case Identification: [Redacted]  
Agency Debt Identification: [Redacted]

Dear [Redacted]

Your unpaid delinquent debt owed to the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare Overpayments (Not eligible for PCA), has been referred to the U.S. Department of the Treasury for collection. According to the records of the Department of Health and Human Services, you owe \$71,547.55.

Collection action will continue unless you make payment, within ten (10) days from the date of this letter, in the amount of \$71,547.55, which includes all applicable fees, interest, and penalties, as of today.

If you wish to avoid further collection action and additional charges, you must immediately pay your debt. Your check or money order should be made payable to the U.S. Treasury-FMS. To ensure proper credit to your account, please include the FedDebt Case Identification Number 2008169113A in the memo section of your payment. Please note that we accept credit card payments via MasterCard, Visa, Discover, or American Express. Please send your payment with the attached PAYMENT COUPON to:

U.S. Department of the Treasury - FMS  
Debt Management Services  
Post Office Box 70950  
Charlotte, NC 28272-0950

You may also make an electronic payment via pay.gov:  
(<https://www.pay.gov/paygov/forms/formInstance.html?agencyFormId=16531440>).

Correspondence should be mailed to: U.S. Department of the Treasury  
Debt Management Services  
Post Office Box 830794  
Birmingham, AL 35283-0794

If you are unable to pay your debt in full, please contact a Customer Service Representative toll free at (888) 826-3127, or the Telecommunications Device for the Deaf (TDD) at (866) 896-2947.

U. S. Department of the Treasury  
Debt Management Services

DSBDL\_\_003\_\_ fdv1

Detach Here  
PAYMENT COUPON

00000008882008169113A DL\_\_0012788006 108

FedDebt Case Identification Number: 2008169113A  
Amount Due: \$71,547.55  
Amount Enclosed: \_\_\_\_\_

[Redacted]

METHOD OF PAYMENT (SEE INSTRUCTIONS)

# About Your Speaker

- Vice President/ DecisionHealth Professional Services
- Former Senior Partner/ The CMC Group
- Former Senior Analyst/Compliance Consultant for Tenet Physician Services
- Former Physician Services Consultant for HCA/The Healthcare Company
- Dual Coding Certification through AAPC (CPC, CPC-P)
- Certified Compliance Professional (CCP-P)
- Advanced Certification Specialty (Evaluation and Management Services)

Rack – A device of torture used in Medieval times



[www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)

# **CMS Resumes RAC Activity After Protests**

- Protests were filed with GAO by two unsuccessful bidders for the permanent RAC Program.
- As a result, CMS is required to impose an automatic stay on the contract work of the 4 RACs that were awarded contracts.
- The automatic stay will remain in place until GAO makes a determination. GAO has 100 days to issue its which brings us to early February.

# RACs and Their Role in Audit Recoveries

- Recovery Audit Contractors (RACs)
- Authorized by MMA•3 year demonstration project
- Florida, NY, and California
- Look at claims at least one year old
- Identify under-and over payments
- Paid on a contingency basis–On overpayments identified
- Began May 2005
- May not look at pure over coding of E&M services –at least not now!
  - May look for medical necessity & global surgery package, CCI edits, multiple surgery rules.

# About RACs

- RAC Requests for \$\$ Back
- Check that you were paid
- If multiple surgery rule, was it in place that year for that code?
- If CCI issue, was the claim initially denied but paid on appeal?
- If you disagree, normal appeal rights apply.–But, must send in requested overpayment

# **RAC: CMS Recovery Audit Contractors**

<b>Type of RAC</b>	<b>Recovery Percentage</b>
Claims RAC	96%
Medicare as Secondary Payer RAC	4%

## **Outcome:**

\$300 million in inappropriate payments identified

\$290m overpayments

\$10m underpayments (only \$3m refunded)

Underpayment strategy not in favor of the provider.

# Types of Notifications

**Automated** – demand for repayment

- ie: CPT 36430 only one unit per day allowed
- (30 days to dispute / 41 days to refund)

**Complex** – requires medical record review

- ie: DRG assignment / sequencing
- (60 days to review)

Both come by mail,

Both are uncovered by data mining.

# Pilot Program for 3 Years

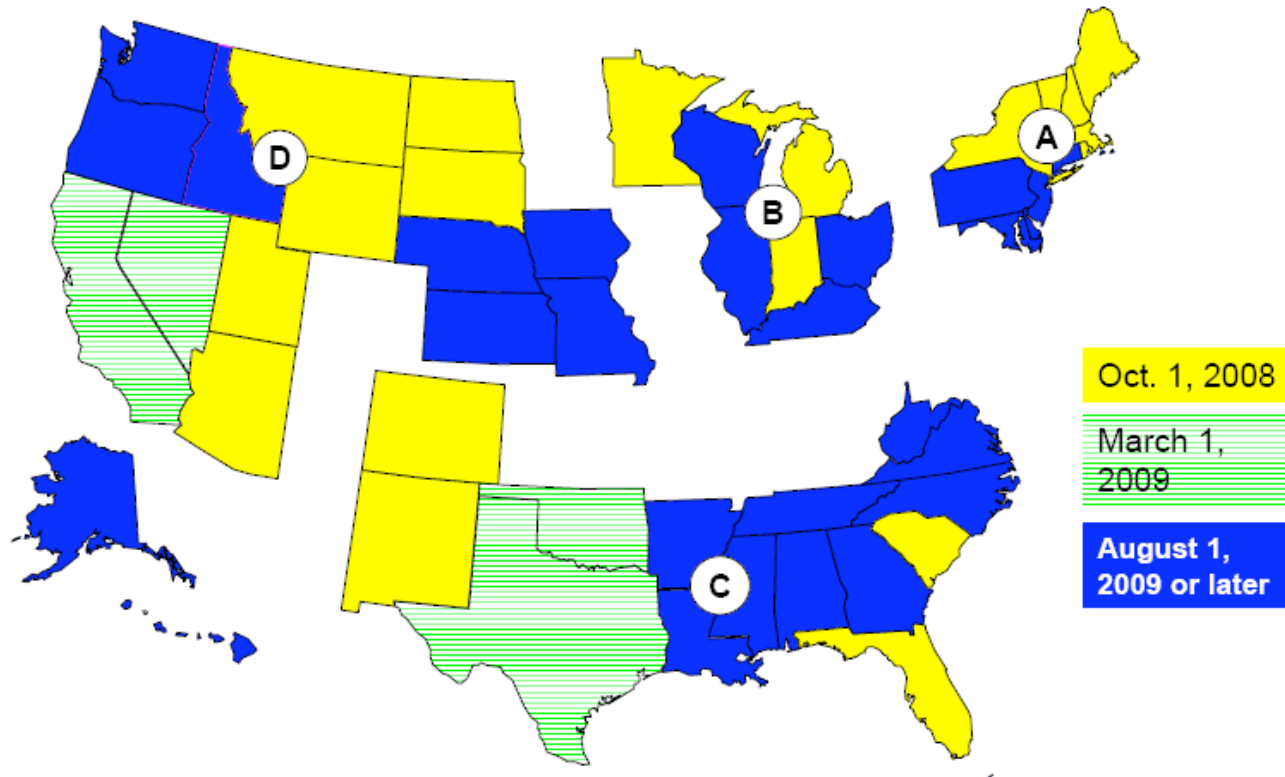
- **California:** inpatient hospital / SNF, DME, IRF and physician claims.
- **Florida:** physician claims.
- **New York:** hospital inpatient & outpatient claims.
- CMS: “RAC...a very cost effective program.”
- “...achieved a respectable return on investment of 373% in 2006” (2006 RAC Status Report)

# RAC Expansion

- CMS announced the 4 new permanent RACs on October 6<sup>th</sup>:
  - **Diversified Collection Services, Inc. of Livermore, CA:** *Region A* (ME, NH, VT, MA, RI, NY).
  - **CGI Technologies and Solutions, Inc. of Fairfax, VA:** *Region B* (MI, IN, MN).
  - **Connolly Consulting Associates, Inc., of Wilton, CT:** *Region C* (SC, FL, CO, NM).
  - **HealthDataInsights, Inc. of Las Vegas, NV:** *Region D* (MT, WY, ND, SD, UT, AZ).
- Additional states will be added to each region in 2009.

# RAC Map

## RAC Expansion Schedule





# Permanent RAC Program

- CMS will not be contracting with MSP RACs in the permanent program.
- RAC Contingency Fees:
  - Region A – 12.45%
  - Region B – 12.50%
  - Region C – 9%
  - Region D – 9.49%
- On October 9<sup>th</sup>, CMS appointed the RAC Validation Contractor (RVC): Provider Resources, Inc. of Erie PA
  - Approves new issues the RACs want to pursue for improper payments.
  - Performs accuracy reviews on a sample of randomly selected claims on which RACs have already collected overpayments.

# Key Differences in RAC Permanent Program

- RACs are required to employ a full-time medical director to assist in the review of claims.
- RACs are required to have certified coders.
- “Look-Back” period has been reduced from 4-yrs to 3-yrs.
- Maximum look-back date 10/1/07.
- Mandatory internal audits.
- RAC claim status web page established by January 2010.
- Mandatory external validation process.
- RACs are required to return contingency fees if an overpayment determination is overturned at any level in the appeals process.

# RAC Demonstration vs. RAC Permanent Program

Issue	Demonstration RACs	Permanent RACs
RAC medical director	Not Required	Mandatory
Coding experts	Optional	Mandatory
Credentials of reviewers provided upon request	Not Required	Mandatory
Discussion with CMD regarding claim denials if requested	Not Required	Mandatory
Minimum claim amount	\$10.00 aggregate claims	\$10.00 minimal claims
AC validation process	Optional	Limited
External validation process	Not Required	Mandatory
RAC must payback the contingency fee if the claim is overturned on appeal	Only required to pay back if claim is overturned on the first level of appeals	Required to pay back if claim is overturned at all levels of appeals
Vulnerability reporting	Limited	Frequent and mandatory

# RAC Demonstration vs. RAC Permanent Program (cont'd)

Standardized base notification of overpayment letters to providers	Not Required	Mandatory
Look back period (from claim pmt date - date of medical record request)	4 years	3 years
Maximum look back date	None	10/1/2007
Allowed to review claims in current fiscal year?	No	Yes
Limits on # of medical records requested	Optional. Each RAC set own limit	Mandatory. CMS will establish uniform limits
Time frame for paying hospital medical record photocopying vouchers	None	Within 45 days of receipt of medical record
MSP included	Yes	No
Quality assurance/ Internal control audit	No	Mandatory
Remote call monitoring	Yes	Yes
Reason for review listed on request for records letters and overpayment letters	Not Required	Mandatory
RAC claim status Web page	Not Required	By January 2010
Public disclosure of RAC contingency fees	No	Yes

# Key Concept

- RACs are not intended to replace other review efforts by:
  - Fiscal Intermediaries,
  - Part B and DME Carriers,
  - Program Safeguard Contractors (PSC),
  - Benefit Integrity Support Centers (BISC)
  - Quality Improvement Organizations (QIO) or
  - the Office of Inspector General (OIG).

# Familiar Problem Areas

## Inpatient

- Skin graft &/or debridement for skin ulcer or cellulitis (263)
- Wound debridement and skin graft (217)
- Medical back problems (243)
- Septicemia, age greater than 17

## Outpatient

- Neulasta (J2505)
- Speech/hearing therapy (92507)
- Blood transfusion service (36430)

# The RAC Process: Claim Selection

- Must “target” claims through data analysis.
  - Cannot randomly select claims.
  - Cannot just focus on high payment claims.
- What claims are targeted?
  - Claims with incorrect payment amounts;
  - Non-covered services – including services not reasonably necessary;
  - Incorrectly coded services (including DRG); and
  - Duplicate services.

# Claim Selection

- RACs cannot audit claims for:
  - Services not included in Medicare FFS;
  - Cost report settlement process;
  - A random selection of claims;
  - Claims with “special processing numbers” (such as demonstration projects); or
  - Claims in a prepayment review.

# Claim Selection

- RACs cannot also audit claims that have been audited by “Affiliated Contractors (AC),” which means DME MAC, Part B carrier, QIO, or FI.
- Also, RACs will not audit services under investigated as part of potential fraud cases by Benefit Integrity Program Safeguard Contractors or law enforcement agency (OIG, DOJ).
- CMS is requiring a validation process to ensure no duplicate audit of claims.

# Claim Selection Example: Orlando Regional Healthcare

- RAC in Florida identified these services:
  - Excisional debridement
  - Sepsis
  - Single CCs
  - Coagulopathy
  - One-day stays
  - Inpatient rehabilitation services
  - Outpatient services
  - Discharge status and readmissions

# Claim Selection

- What might a RAC audit in a physician practice?
  - Joint injections.
  - Lesion destruction and excisions.
  - Laceration Repair.
  - E/M services might be identified and audited through a closer examination of procedure codes (e.g. a charge for a high level E/M code for pre-op H & P just a few days before the procedure would be disqualified).

# **RAC Audit Areas and Top Errors for Physicians**

- Excessive/Multiple Units 54%
- Duplicate Claims 5%
- All Other Physician Overpayments 41%

# RAC FOCUS AREAS

- CMS Status Report on overpayments identified by RACs in fiscal year 2007:
  - 42% Incorrectly Coded
  - 32% Medically Unnecessary Service or Setting
  - 9% No/Insufficient Documentation
  - 17% Other

# Claim Selection

- What about E/M services? Generally these are not subject to a RAC audit.
- Exceptions:
  - E/M services that are not reasonable and necessary.
  - Violations of Medicare global surgical billing and payment rules.

# Claim Selection

- What is the time period?
  - Under the demonstration, the “lookback” was four years.
  - New limit is three years but none earlier than October 1, 2007.
    - For now, the “lookback” period is much shorter.

# Claim Selection: Automated

- There are two types of RAC reviews: “automated” and “complex.”
  - Automated: no medical records involved in the review, certainty that overpayment exists based on data review.
    - Data crunching combined with a written Medicare policy, article or sanctioned coding guideline.
    - This also includes duplicate claims.
    - Note: If the RAC identifies a “clinically unbelievable” claim (the codes on the claim cannot be accurate but there is no written policy), RAC may seek CMS approval for an automated review.

# Claim Selection: Complex

- Second type of review: “complex”.
  - Medical records are involved in the review, high probability (but not certainty) that the service is not covered.
    - The RAC will request medical records from the provider to further review the claim. The RAC would then make a determination as to whether payment of the claim was correct, an overpayment, or an underpayment.
    - This is similar to current processes by carriers.

# Medical Record Request?

- CMS says it will limit the number of records a RAC can request.
  - To date, we do not have the actual number, but CMS says it will vary depending on the size of the facility. However, “50” per provider per month seems to be the thinking.
    - This number, though, may not meet a statistically valid sample.

# Medical Record Request

- RACs may obtain medical records by going onsite to your location to view/copy the records or by requesting that you mail/fax or securely transmit (NOT email) the records to the RAC.
  - Note: If you refuse to allow access, the RAC cannot make an overpayment determination based upon lack of access, but must instead request the records in writing.

# Medical Record Request

- Providers will have 45 days to respond.
  - This means you must provide the records within 45 days, or request an extension within 45 days.
  - If you do not respond, the RAC must attempt to contact you one more time.
  - If you still do not respond, the RAC may find a claim to be an overpayment.

So What Happens?

# Basic Steps

- Steps in the Process
  1. Receiving RAC Request.
  2. Responding to RAC Request.
  3. Notification of Outcome.
  4. Appeal Processes.

# 1. Receive Request

- You would receive a letter from your RAC, typically sent to the physician, administrator, or an individual you have designated as the “RAC Liaison.”
- Don’t panic, but don’t take this lightly – a Medicare audit is similar to one by the IRS: You are guilty until proven innocent. The burden of proof is on your shoulders.

## 2. Respond to a Request

- Initial questions when preparing response.
  - Are there any previously evaluated claims?
  - What amount of detail should you submit?
- Begin preparation.
  - Gather and copy all appropriate documents requested by the RAC.
  - Review all information regarding the information being audited.
  - Make sure if there were referrals from other providers you have a record of such requests.
  - Where else besides the patient chart would information be maintained?
  - Are there records at the hospital you may need or from other providers involved in the patient's care?
- Don't forget to ask for an extension if needed.

# 3. Notification of Outcome

- RACs will only provide results of an automated review if there is an overpayment.
- For complex reviews, RACs have 60 days to complete audit after receiving records.
- RAC letter should contain:
  - Audit results, identifying overpayments and underpayments.
  - Coverage, coding or payment policy or article violated.
  - Rights of appeal.
  - Contact information.
  - Payment refund procedures.

# Overpayments

- RACs cannot recoup overpayments of less than \$10.
- For all over overpayments, RACs must follow the same practice as Medicare carriers, though RACs cannot make claim adjustments (only carriers can).
- KEY: RAC overpayments will be through recoupment (and through installments, if requested.)

# Overpayments

- On delinquent accounts, RACs will turn the account over to the Dept of Treasury.
- Interest? Yes.
  - It will accrue from the date of the final determination and be charged on an overpayment balance for each 30 day period that payment is delayed. Any payments received will be first applied to any accrued interest and then to any remaining balance.

## 4. Appeals Process

- The Medicare Appeals process will remain the same for physicians under Part B and Part A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the PPS. In the current appeals process, the first level appeal will go to the Quality Improvement Organization (QIO); however, the RAC appeals will go to the FI that processed the claim.

# Appeals

- First level – redetermination. This is a written request within 120 days to your carrier or FI (not the RAC). The carrier/FI has 60 days to respond.
- Second level – reconsideration. This is a written request on a standard CMS form within 180 days to your Qualified Independent Contractor. The QIC has 60 days to respond.

# Appeals

- Third level – ALJ hearing. This is an in-person, telephone, or videoconference hearing. You must request the hearing 60 days after the reconsideration. The amount in controversy must be \$120.

# RAC Appeals Process

- In general, RAC determinations may be appealed in the same manner as any Medicare appeal –
  - *First Level* – Redetermination by the Medicare contractor
  - *Second Level* – Reconsideration by the Qualified Independent Contractor (QIC)
  - *Third Level* – Hearing by an Administrative Law Judge (ALJ).
- Except:
  - The RAC initial determination is appealed to the Medicare contractor that initially paid the claim; not the RAC that made the initial determination.
  - Providers may informally dispute claims to the RAC prior to appealing. If the RAC agrees with the provider, the RAC will not issue a payment reduction to the Medicare contractor. If the RAC disagrees with the provider, the RAC notifies the contractor of the payment adjustment.

# Results of the Demonstration Project: Appeals of RAC Determinations (Claims Only, Through 6/30/08)

- Providers appealed 19.6% of RAC determinations through June 30, 2008.
- 6.8% of appeals were overturned.
- As of June 30, 2008, there were an additional 1,607 claims pending at the ALJ.

Number of claims with overpayment determinations	525,133
Number of claims where provider appealed (any level)	102,705
Number of claims with appeal decisions in provider's favor	35,819
Percentage of appealed claims with a decision in provider's favor	34.9%
Percentage of claims overturned on appeal	6.8%

Source: RAC invoice files, RAC Data Warehouse, and data reported by Medicare claims processing contractors.

Level of Pending Appeal	Number of Claims	Value of Claims (Million Dollars)
Pending at ALJ	1,607	\$12.0

Source: Administrative Qualified Independent Contractor (AdQIC)

# Appeal Tips

- Document all communication between you and RACs, carriers/FI, ALJ, etc.
- Research supporting documentation to help your case.
- Review appeal documentation to ensure it is complete, accurate and convincing.
- Be on time!

# Preparing for a RAC Audit

# Preparing for a RAC Audit

- Designate an individual to serve as the RAC liaison.
  - Compliance officer?
  - HIM director?
  - Administrator? Office manager?

# Preparing for a RAC Audit

- Learn what may be a target of the RAC:
  - National areas of focus and type of review:
    - Debridement (complex)
    - Respiratory Failure (complex)
    - Medical back pain (complex)
    - Transfusion codes (automated)
    - Speech therapy (automated)
    - Neulasta (chemotherapy) (complex)
  - Conduct your own internal data mining.
    - High volume services

# Responding to a RAC Audit

- Document and track RAC audit requests as well as your responses.
  - Perhaps use a system to organize the requests by type of issue and financial impact.
- Verify that the claim is open for RAC to review.
  - Do not assume RAC database is accurate.
  - If you conclude line item on claim has already been reviewed, notify RAC, FI, QIO, etc.

# Responding to a RAC Audit

- Review each request carefully.
  - Use a qualified individual to perform internal audit.
  - Prioritize review of claims by time remaining to respond; financial impact; and volume of claims with common issues.
    - Goal is to avoid any technical denials.
  - If volume of requests / demands is determined to be excessively burdensome, formally request extension to RAC.

# Responding to a RAC Determination

- First question: Is RAC's determination of overpayment correct?
  - Understand the specific rules / policies included in the determination letter.
    - Do not blindly accept RAC interpretation of rules/ guidelines.
    - Look to see if policy / rule has changed over time.
- Second question: Is an appeal warranted?

# Responding to a RAC Determination

- Consider appealing medical necessity denials. Why?
  - Medical necessity inherently subjective.
  - LCDs have not been subjected to serious clinical scrutiny and change often.
- Identify underpayments on both RAC targeted claims and others.
  - Request waiver of timely filing deadlines for identified underpayments.

# Responding to a RAC Determination

- When an overpayment is correct, determine and implement corrective action to avoid repeated scrutiny.
  - If desired, ask to pay on an installment plan.
  - Ask for partial payment whenever possible.
  - Determine if others (patients, payers) will pay denied claim.

# Final Thoughts

- Continue to be proactive in your coding/billing.
  - Submit corrected claims.
- Take immediate action when RAC letters are received.
- Provide education to all individuals based on RAC findings (and document education attendance.)
- Evaluate the need for external assistance and guidance to help navigate your internal RAC team through the process.

# Final Thoughts

- If you disagree with the RAC determination, file an appeal before the 120-day deadline.
- Keep track of denied claims and correcting these previous errors.
- Determine what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future.

# RAC FOCUS AREAS

- CMS did not mandate which claims RACs had to review
- Selection methodology is left up to the RAC
- RACs often review services highlighted by OIG
  - Review OIG Work Plans

# Are RACs Here to Stay?

- CMS considers RACs to be an effective tool for identifying improper payments made by the Medicare program.
- On 7/11/08, Representative Pete Stark (D-CA), Chairman of the House Ways and Means Health Subcommittee, wrote to the GAO requesting a study of the RAC demonstration project before the expansion of the RAC program. The letter did not mention a timeline for completion of the study.
- *“Medicare Recovery Audit Contractor Moratorium Act of 2007” (H.R. 4105)* –
  - Introduced by Representative Lois Capps (D-CA) on 11/7/07.
  - Seeks moratorium on the RAC expansion.
  - 105 Cosponsors (as of 10/30/08); no companion bill in the Senate.
  - Future unknown with the new Administration.

# Future of Program Integrity Efforts

- **OIG**
  - 2009 Work Plan: The OIG intends to review CMS' oversight and monitoring of RACs to determine whether they meet contractual requirements outlined in the RAC Task Orders.
- **CMS**
  - CMS is consolidating the work of Medicare's Program Safeguard Contractors (PSCs) and the Medicare Drug Integrity Contractors (MEDICs) with the new Zone Program Integrity Contractors (ZPICs).
  - ZPICs will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B, Part C, Part D, and coordination of Medicare-Medicaid data matches.
  - CMS awarded the first two new ZPIC contracts to Health Integrity, LLC for Zone 4 (Texas, New Mexico, Colorado, and Oklahoma) and SafeGuard Services LLC for Zone 7 (Florida, Puerto Rico, and US Virgin Islands).

Thank You For Joining Us  
Please ask your questions

Sweiss@decisionhealth.com

C: 770-402-0855

O: 888-262-8354