

February 25, 2009

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*via email: heckel@kyma.org*

Ms. Sharon Heckel  
Managing Editor  
Journal of the Kentucky Medical Association  
4965 U.S. Highway 42, Suite 2000  
Louisville, Kentucky 40222-6372

RE: *Proposed Article on Physicians Preparing Their Practice  
for Recovery Audit Contractors*

Dear Sharon:

Attached (electronically) to this letter is a proposed article authored by me and one of our health law associates at Stites & Harbison, Amanda Nall, on the subject of physicians preparing for the Recovery Audit Contractor program which is to be implemented in Kentucky some time around August or September of 2009. I believe the article is self-explanatory and would be of interest to Kentucky physicians.

With respect to the copyright assignment, we certainly consent to publication in the *Journal of the Kentucky Medical Association* but, unless you object, we also intend to make appropriate modifications to the article and offer it for publication in other health-related media. If that poses a problem for KMA, please let me know and we will sign the formal copyright assignment as described in your "Guidelines for Authors."

We are not aware of any potential conflict which might exist between ourselves and other entities or persons with respect to this article.

Thanks very much for your consideration. Please do not hesitate to call if you have any questions or if I can provide any further information.

Ms. Sharon Heckel  
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Yours very truly,

STITES & HARBISON PLLC



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## **“RAC and Roll”: Preparing Your Practice for the Recovery Audit Contractor Program**

**By: Charles J. “Mike” Cronan IV and Amanda Schroering Nall**

*Mike Cronan and Amanda Nall are members of the Stites & Harbison, PLLC Health Care Service Group in Louisville.*

You arrive in your office and find a letter from a government contractor on your desk titled “Medical Records Request Letter.” The contractor is being paid a percentage of any billing errors it discovers. Someone in your office must locate fifty medical records, as well as review, copy, log in to a database or spreadsheet, package and mail those documents ... all within forty-five days. Where do you begin?

In the upcoming months, you will be hearing more about the Centers for Medicare and Medicaid Services (“CMS”) using Recovery Audit Contractors (“RACs”) to recover improper payments for Medicare services. During a demonstration program in a few chosen states, CMS tasked RACs with reviewing samples of Medicare claims to detect improper billing, and returning any improper payments to the government or to the provider or supplier (“supplier” includes physicians). Because CMS viewed the demonstration project as a success, it is expanding the use of RACs to a permanent national program that is to be fully operational by 2010. This article provides background on the RAC demonstration program and responses to it, as well as information about the permanent RAC program and suggestions as to what actions physician practices should take in preparation for the national implementation of this program.

### **Background on the RAC Demonstration**

A January 2008 report by the Office of Management and Budget found that Medicare is one of the top three Federal programs with incorrect payments, adding up to an estimated \$10.8 billion in 2007.<sup>1</sup> Improper payments on Medicare claims occur for a variety of reasons,

including payments made for (1) services that do not meet Medicare's medical necessity criteria, (2) payments for incorrectly coded services, (3) the submission of duplicate claims, or (4) claims paid by Medicare that should have been paid by an insurance company. As Kerry Weems, CMS's Acting Administrator stated, "[b]ecause Medicare pays for medical services and items without looking behind every claim, the potential for waste, fraud and abuse is high."<sup>2</sup> Therefore, the government has vowed to improve its oversight efforts to "better ensure that Medicare dollars are being used to pay for equipment or services that beneficiaries actually received while protecting them and the Medicare Trust Fund from unscrupulous providers and suppliers."<sup>3</sup>

Accordingly, Section 306 of the Medicare Modernization Act of 2003 directed RACs to identify improper payments and to return the overpayments to the Medicare Trust Fund. In March of 2005, CMS began a three-year pilot demonstration project in the three states with the highest Medicare expenditures: California, Florida, and New York. Massachusetts, South Carolina, and Arizona were added to the program in 2007. The initial rollout of the RAC program involved two types of RACs: Medicare Secondary Payer ("MSP") RACs, which identified situations where Medicare should not have been the primary payer; and, "Claim" RACs, which identified payment errors, such as coding errors, payments for non-covered services, and duplicate claims.<sup>4</sup> Given access to national claims data, the RACs used software to identify claims that contained errors resulting in improper payments. Certain claims were excluded from the RAC search, including: Medicare Parts C & D; claims over four years old; claims previously reviewed by another Medicare contractor; and claims that were already being reviewed in fraud investigations.<sup>5</sup>

Interestingly, CMS reimbursed the RACs using a contingency-based (percentage of overpayments recovered) payment model, marking the first time the Medicare program paid a contractor on a contingency fee basis. Some groups argued that this model provided a financial motivation to the RACs to aggressively challenge claims. CMS deemed this type of payment methodology proper “because it has been the accepted standard practice among private health care payers for more than twenty years.”<sup>6</sup> However, CMS’s use of a contingency fee structure is a curious step in light of its longstanding concern that percentage billing arrangements in other contexts, such as compliance with fraud and abuse laws, increase the risk of abusive practices.

Since the program began in 2005, the RACs have identified nearly \$1.03 billion in Medicare payments that they deemed to be improper.<sup>7</sup> Approximately 96% of the payments were overpayments recovered from providers and suppliers, while the remaining 4% were underpayments paid back to providers and suppliers, resulting in a total of \$693.6 million returned to the government.<sup>8</sup> CMS calculated the cost of the program at only \$0.20 per dollar returned to the Medicare Trust Fund.<sup>9</sup>

Approximately 85% of the overpayments were collected from inpatient hospitals, 2% were collected from physicians, and the remainder were collected from facilities such as outpatient hospitals and skilled nursing facilities.<sup>10</sup> While 2% may sound like an insignificant amount, it translated into \$19.9 million collected from physicians, with \$1.0 million of that attributable to the submission of duplicate claims.<sup>11</sup> One explanation for the RACs’ high rate of overpayment recovery from hospitals is that CMS allowed each RAC to determine which claims it would target for review. CMS recognized that, because of the contingency fee payment structure, the RACs most often targeted potential “high-dollar” improper payments, such as inpatient hospital claims.<sup>12</sup> While the permanent RACs will most likely continue this strategy

with the national rollout of the RAC program, physicians will still need to ensure that they have appropriate procedures in place to respond to RAC medical records requests and to appeal RAC decisions.

CMS found that health care providers and suppliers were mostly satisfied with the RAC demonstration program. Telephone interviews conducted by the Gallup Organization with a sample of providers and suppliers who had received a RAC medical record request or overpayment request revealed that 74% of the respondents felt CMS's efforts to recoup overpayments were fair and reasonable, and that 71% thought that RAC reviews accurately employed Medicare policies.<sup>13</sup>

However, not all physician practices in the three demonstration states had a good experience with the initial RAC project. William Dolan, a member of the Board of Trustees of the American Medical Association and a practicing orthopedic surgeon from New York, testified before the Subcommittee on Regulations, Health Care and Trade of the U.S. House of Representatives, about the impact of CMS regulations and programs on small health care providers.<sup>14</sup> He noted that, "[a]pproximately 53 percent of physician practices are comprised of fewer than three physicians and 75 percent of physician practices are composed of fewer than eight physicians. For the majority of these small physician practices, burdensome regulations can take valuable time away from patient care ... [w]e have significant concerns with the [RAC] program ..."<sup>15</sup> He testified that the pilot program was burdensome on physicians and did nothing to educate them about billing mistakes, while providing RACs with incentives to deny claims.<sup>16</sup>

## **National Rollout of the RAC Program**

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and mandated that the program be expanded to all fifty states by no later than 2010.<sup>17</sup> CGI Technologies and Solutions, Inc. (“CGI”) of Fairfax, Virginia, has been named the RAC for the region including Kentucky and Indiana.<sup>18</sup> CGI’s work is to begin in Kentucky starting August 1, 2009 and in Indiana starting March 1, 2009. On November 1, 2008, PRG-Schultz, Inc. and Viant, Inc., both unsuccessful bidders for RAC contracts, asked the GAO to require CMS to redo the RAC selection process.<sup>19</sup> The GAO had one-hundred days to decide if CMS erred when selecting the permanent RACs, during which CMS enforced a stay of performance.<sup>20</sup> On February 4, 2009, the parties involved settled the protests, and the stay was lifted, enabling CMS to continue with the implementation of the permanent RAC program. It is unclear at this point whether this delay will effect the dates for expansion of the program into Kentucky and Indiana.

As they did in the demonstration program, the permanent RACs will use data scrubbing techniques to perform two types of reviews of claims data. One type of review performed by the RACs will be an “automated review” in which the RAC will identify clearly improper payments, including payments for services not covered by Medicare, duplicate payments, and incorrect units of service. The other type of review, a “complex” review, involves the RAC’s request of medical records from the physician using a “Medical Records Request Letter” to review, in greater detail, claims that likely contain errors. The physician has forty-five days to submit copies of the requested charts, or the RAC has the authority to find that the claim was overpaid. After the RAC’s review of the medical records, it forwards its decision to the physician within 60 days, and, where the RAC finds an overpayment, it forwards a demand letter asking for a repayment of the funds.<sup>21</sup>

Physicians may appeal the decision using the five-level Medicare Part A and Part B appeals process involving the following steps:

- The first step is submission of a redetermination request to the fiscal intermediary (“FI”) that processed the claim within 120 days of receiving the notice of initial determination;
- Within 180 days of receiving notice of an adverse redetermination decision, the physician may file a request for reconsideration of the FI’s opinion with a qualified independent contractor (“QIC”);
- Next, the physician may file a request for an Administrative Law Judge (“ALJ”) hearing within 60 days following the QIC’s reconsideration decision;
- The physician may then file a request for a Medicare Appeals Council (“MAC”) Review within 60 days following receipt of the ALJ’s decision;
- Finally, the physician may file a request for review in federal district court within 60 days of receipt of the MAC’s decision.<sup>22</sup>

Additionally, the interest rate on the overpayment accrues, and a physician practice is obliged to pay this amount in addition to the overpayment amount, if the appeal is denied. As of August 31, 2008, providers and suppliers had appealed 22.5% of the RAC determinations, of which 7.6% were overturned on appeal.<sup>23</sup>

With the national rollout, CMS has tried to deal with some of the problematic issues that physician practices encountered during the demonstration project.<sup>24</sup> Medicare’s contingency fee arrangements with RACs have been the focus of criticism from various groups and health care providers. At the outset of the demonstration program, RACs received contingency fees based only on the amount of Medicare overpayments returned to CMS. They received no fee for detecting underpayments reimbursable to physicians or hospitals. CMS now has confirmed that

it will continue to pay RACs on a contingency fee basis, but it will establish the payment on the percentage of overpayments returned to the government as well as the percentage of underpayments returned to providers. Moreover, the RACs will now be required to return any contingency fees when a payment decision is overturned at any stage of appeal, whereas in the pilot demonstration, the RAC could keep the fee if the RAC's decision was affirmed at the first level of appeal but overturned at a later stage of appeal. However, physician practices will still need to be mindful of the potential for bias that the contingency fee payment model creates and be sure to carefully monitor the RAC's actions to ensure that they are complying with established Medicare policy and procedure.

Additionally, in the initial demonstration RACs had no limit on the number of claims for which they could request documentation from a particular provider. Consequently, some RACs were criticized for being overly aggressive and participating in "fishing expeditions" that depleted provider resources. With the permanent program, CMS will limit the number of medical records that a RAC may request, employing a "sliding scale" depending on the size of the practice.<sup>25</sup> The limit for physician solo practitioners is ten medical records per forty-five days; twenty medical records per forty-five days for physician partnerships of two to five individuals; thirty medical records per forty-five days for physician groups of six to fifteen individuals; and, fifty records per forty-five days for large groups of sixteen or more physicians.<sup>26</sup>

CMS also has promised other modifications as it transitions RAC into a permanent program. CMS has mandated that either CMS or an independent RAC Validation Contractor must validate all new issues that a RAC desires to pursue for overpayments, including medical necessity reviews of claims. Additionally:

- Each new RAC must employ a physician medical director and certified coders;
- The “look-back” period for claims will change from four years to three years;
- No claims dated earlier than October 1, 2007 may be reviewed by the RACs; and,
- Each RAC must add a Web-based application that will enable providers and suppliers to review the status of medical record reviews.<sup>27</sup>

### **What Can Physicians Do to Prepare for RAC Audits?**

Physician practices should take advantage of the time remaining before the permanent RAC program is implemented in Kentucky and Indiana. Physicians can prepare for the upcoming RAC audits by ensuring that their office staff and practice managers are aware of the program and are attuned to the possibility of receiving a request for records, to which a response must be made in forty-five days. One person should be designated as the point of contact between the office and the RAC.<sup>28</sup>

Physicians also should create and put into operation an internal response plan that includes key dates for compliance with the records request and appeal steps.<sup>29</sup> For example, the physician must be prepared to track the request from the point of its initial receipt by the physician’s office, and to ensure that a timely response is made. Review all medical records and other documentation given to RACs to be assured that the information is accurate and complete. Retain copies of every document submitted to the RAC. To the extent records since October 1, 2007 are stored offsite, consideration should be given to the most efficient way to retrieve them to assure a timely response. What may initially seem like a simple medical record request could turn into quite a large job if the correct tools and processes are not in place.

Retrospective and prospective internal audits on issues that CMS has targeted are another way that physicians can prepare for RAC audits.<sup>30</sup> Through these self-audits, physicians can

identify any non-compliant coding procedures and, with the help of legal counsel or billing and coding consultants, revise coding policies and guidelines as necessary to conform to Medicare's criteria. The OIG Work Plan<sup>31</sup> for the current year identifies target areas and top coding issues that RACs will be examining. Areas identified in the Work Plan, as well as the areas identified by CMS as having the highest amount of overpaid claims, provide helpful guidance as to those areas in which the staff should be properly trained.<sup>32</sup>

With the financial success and the ongoing expansion of the RAC program, it is clear that the government's focus on uncovering improperly paid claims is here to stay. Physicians and their counsel should prepare now to manage the RAC process.

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<sup>1</sup> "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 1, June 2008, *available at* [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>2</sup> "CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse in Medicare," October 6, 2008 Press Release, CMS Office of Public Affairs, *available at* <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3291>.

<sup>3</sup> *Id.*

<sup>4</sup> "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 1, June 2008, *available at* [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>5</sup> *Id.* at pp. 12-13.

<sup>6</sup> *Id.* at p. 11.

<sup>7</sup> *Id.* at p. 2.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* at p. 3.

<sup>10</sup> *Id.* at p. 19.

<sup>11</sup> *Id.* at p. 38.

<sup>12</sup> *Id.* at pp. 12 and 18.

<sup>13</sup> *Id.* at p. 2.

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<sup>14</sup> “Statement of the American Medical Association to the Committee on Small Business Subcommittee on Regulations, Health and Trade,” *available at* <http://www.house.gov/smbiz/hearings/hearing-05-14-08-CMS-Regulations/Dolan.pdf>.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *See* 42 U.S.C. § 1395ddd.

<sup>18</sup> *See* “RAC Permanent Program” Press Release, *available at* <http://www.cms.hhs.gov/RAC/>.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *See generally* “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 12, June 2008, *available at* [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>22</sup> 42 C.F.R. § 405.900 *et seq.*

<sup>23</sup> *See* “The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration,” at p. 4, January 2009, *available at* <http://www.cms.hhs.gov/RAC/Downloads/AppealUpdatethrough83108ofRACEvalReport.pdf>. Please note that CMS estimates that the majority of first-level appeals should have been filed by July 1, 2008. Many of the claims are in various stages of the appeals process and may still be overturned.

<sup>24</sup> *See generally* “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 3, June 2008, *available at* [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>25</sup> The RAC Medical Record Request Limits for FY 2009 are available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf>.

<sup>26</sup> *Id.*

<sup>27</sup> *See generally* “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 3, June 2008, *available at* [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

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<sup>28</sup> See “Strategic Assessment: Prepare Now for RAC Auditors – 4 Steps to Risk Mitigation,” Carla Engle, February 2008, available at [http://www.heops.com/news\\_RAC\\_Audit.php](http://www.heops.com/news_RAC_Audit.php).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> Available at: <http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf>.

<sup>32</sup> See “Strategic Assessment: Prepare Now for RAC Auditors – 4 Steps to Risk Mitigation,” Carla Engle, February 2008, available at [http://www.heops.com/news\\_RAC\\_Audit.php](http://www.heops.com/news_RAC_Audit.php).