GOVERNMENT ENFORCEMENT INITIATIVES FOR REVENUE RECOVERY:

RACs AND OTHERS

presented by

Kathleen Houston Drummy, Esq.

Davis Wright Tremaine LLP
• What is a RAC?
RAC MISSION

As to Fee-For-Service Programs:

- Reduce improper payments
- Detect and collect overpayments
- Identify underpayments
- Implement systems to prevent future improper payments
AND TO GO WHERE NO AUDITOR HAS GONE BEFORE!

RACs are not intended to replace reviews by FI, Part B and DME carriers, program safeguard contractors, benefit integrity support centers, quality improvement organizations or the OIG.
LEGAL BACKBONE OF THE RAC PROCESS

CONGRESSIONAL ACTIONS

- IMPROPER PAYMENT INFORMATION ACT OF 2002
  - Required federal agencies to measure improper payment rates, with a focus on identifying mistakes which change the payment amount
MEDICARE MODERNIZATION ACT ("MMA") OF 2003, SECTION 306

- Directed CMS to conduct a three year demonstration postpayment review program commencing in March 2005
- Focused on a handful of states, principally California, New York, and Florida
- Contingency fee compensation
TAX RELIEF ACT OF 2006, SECTION 302

- Made the RAC program permanent
- Expanded the RAC program to all states by 1/1/10
CONGRESSIONAL INACTION

  - Would have imposed a one year moratorium on the RAC program expansion to permit evaluation before going national
  - No action and not re-introduced this year
But, GAO study requested by Congress last July

- GAO asked to examine the changes implemented in response to lessons learned from the pilot and the incorporation of these changes into the nationwide rollout, including:
  - Provider outreach and actions the Agency has taken to prevent future improper payments in areas identified by the RACs
  - Coordination and interaction with other Medicare contractors
  - CMS oversight of auditing efforts
  - CMS oversight of the interactions between RACs and providers done to quantify and minimize the total burden of compliance
# NEW REGION D RAC

Health Data Insights, Inc. of Las Vegas Nevada

- Region D includes:

<table>
<thead>
<tr>
<th>California</th>
<th>Iowa</th>
<th>Idaho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington</td>
<td>North Dakota</td>
<td>Nevada</td>
</tr>
<tr>
<td>Oregon</td>
<td>South Dakota</td>
<td>Nebraska</td>
</tr>
<tr>
<td>Montana</td>
<td>Utah</td>
<td>Missouri</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Arizona</td>
<td>Alaska</td>
</tr>
</tbody>
</table>

- PRG-Schultz International, Inc. will be a contractor
RAC Phase in Schedule

Timeframes

Claims Available for Analysis | Provider Outreach | Earliest Correspondence
--- | --- | ---
March 1, 2009 | March 1, 2009 | March 1, 2009
March 1, 2009 | March 1, 2009 | March 1, 2009
August 1, 2009 | August 1, 2009 | August 1, 2009

*RACs may not begin reviewing until there is provider outreach in the state*
DID THE PILOT RACs ACCOMPLISH THEIR MISSION?
Medicare costs US taxpayers more than $400 billion every year, “in part because of “Medicare fraud, healthcare providers and patients making false claims and cheating the taxpayers….across the nation, hospitals are sending Medicare improper and fraudulent charges, and it’s costing you big time, nearly $11 billion tax dollars a year.” A government-run “pilot program that sent private auditors to comb through hospital bills in three states looking for Medicare rip-offs” was “able to make hospitals pay back an astounding $240 million” in one year “in just three states.”

KATIE COURIC, CBS EVENING NEWS: FEBRUARY 8
FY 2006 RAC STATUS DOCUMENT

- Page 18: “Achieved a Respectable Return on Investment of 373% in 2006”

- 2007 RAC Status Document
  - ROI dropped to 318%
RAC DEMONSTRATION STATUS DOCUMENT FOR FY 2007:

- California
  - Overpayments: $120.1 million
  - Underpayments: $8.4 million
RAC REVIEW PROCESS
RACs MUST FOLLOW ALL APPLICABLE MEDICARE REGULATIONS

- Payment policies

- Reopening timeframes
  - Relies on 42 CFR 405.980 to reopen claims with “good cause” up to four years after the initial determination

- Appeal rights for providers
AUTOMATED REVIEW

Vs.

COMPLEX REVIEW
AUTOMATED REVIEW: DATA MINING

- Uses proprietary software algorithms to identify over/underpayments that may be detected without medical record review
- No human review
- Applies only to coding and coverage determinations
- Written Medicare policy, article or sanctioned coding guideline exists
COMPLEX REVIEW: HUMAN REVIEW OF SPECIFICALLY REQUESTED MEDICAL RECORDS

- Automated review criteria not met
- High probability that service is not covered
- No Medicare policy, article or sanctioned coding guideline exists
- Provider has 45 days to respond to a request
  - Extension Request within that 45 days
- Reports of Findings
WHAT ARE RACs LOOKING FOR?

- Medical necessity
- Incorrectly coded services
- Incorrect payment amounts
- Duplicate services
RACs paid on a contingency fee basis, they keep a portion of what they identify and collect, if the denials are not contested or are upheld on appeal.

- Contingency fee is negotiated, so varies with RAC
- Possible incentive for distortion of judgment?
- Departure from the way other CMS audit contractors are paid
RACs are paid contingency fees for overpayments recouped and for underpayments paid back to providers, but no fees for mere identifications of improper payments

- **Pilot**: Originally, return fees only if lost at the first level of appeal
- **Permanent**: Return if overturned at any appeal level
CLAIMS WHICH RAC MAY REVIEW

- **Pilot**: No claims from the current fiscal year
- **Permanent**: Claims from the current fiscal year
- Complex reviews must be completed within 60 days (RAC SOW 2007)
LOOK BACK DATES

- **Pilot**: No maximum look back date, so up to four years under the Medicare regulation

- **Permanent**: Three years and no claims paid prior to October 1, 2007

  - “To limit the administrative burden on providers and/or physicians.” CMS RAC Solicitation Q&A

  - Look back period counted starting from the date of the initial determination and ending with the date the RAC issues the medical record request letter (for complex reviews) or the date of the overpayment request letter (for automated reviews)
MEDICAL RECORD LIMIT

- **Pilot**: RACs could set own limits
- **Permanent**: CMS has set mandatory limits

Request for Records from:
- Inpatient Hospital, IRF, SNF, Hospice
  - Limit to 10% of the average monthly medicare claims per 45 days for each NPI, capped at a maximum of 200
- Other Part A Providers
  - Limit to 10% of the average monthly Medicare services per 45 days per NPI, capped at a maximum of 200
- Physicians
  - Sole Practitioner: 10 medical records per 45 days per NPI
  - Partnership of 2-5 Practitioners: 20 medical records per 45 days per NPI
  - Groups of 6-15 Practitioners: 30 medical records per 45 days per NPI
  - Large Group 16+: 50 medical records per 45 days per NPI
- Other Part B Billers (DME, Lab, Outpatient Hospital)
  - 1% of the average Medicare services per 45 days per NPI, capped at a maximum of 200
MEDICAL DIRECTOR AND CERTIFIED CODERS

- **Pilot**: Not required

- **Permanent**: Required
  - Also, RNs or therapists must make coverage/medical necessity determinations
  - Question of who should be making medical necessity determinations
DISCUSSION OF DENIED CLAIM WHEN REQUESTED BY PROVIDER

- **Pilot**: Optional with the RAC
- **Permanent**: Mandatory

* This is outside the normal appeal process
CLAIMS SUBJECT TO REVIEW BY THE PERMANENT RACs

- All audits must be pre-approved by CMS and a validation contractor before review (CMS Solicitation Questions and Answers)

- E&M codes could be reviewed at some point
  - Already could review for duplicate payments, global surgery rule violations, etc.
WEB-BASED APPLICATION

- **Pilot**: None available
- **Permanent**: Mandatory by January 1, 2010
- Approved issued to be posted to a RAC website before widespread review
CLAIMS NOT SUBJECT TO REVIEW UNDER THE PERMANENT RAC PROGRAM

- Services provided under a program other than Medicare FFS
- Cost report settlement process
- Claims more than three years past the initial determination
  - And claims earlier than October 1, 2007
- Claims where the provider is without fault
- Claims with special processing numbers, *e.g.*, Medicare demonstrations
- Suppressed claims, where claim is part of an ongoing investigation
- Claims already reviewed by another Medicare contractor
WHAT IS CMS NOW DOING TO ENSURE ACCURACY?

- New Issue Review Board
  - To provide greater oversight of issues audited by RACs
- RAC Validation Contractor
  - To provide review of RACs’ auditing
  - To provide annual accuracy scores for each RAC
- RAC employment of clinical staff
- RAC’s loss of contingency fee if loses at any appeal level
PREPARING FOR A RAC AUDIT
ORGANIZE A RAC TEAM, ESTABLISH AN INTERNAL PROCESS, AND COORDINATE WITH COMPLIANCE FUNCTION
TRAIN TEAM ON PROCEDURAL ISSUES

- Timing of response to medical record requests
- Timing of extension requests
- What constitutes a burdensome request by the RAC
- Understanding the appeal process
TRAIN TEAM ON
SUBSTANTIVE ISSUES

KNOW THYSELF!

- Review services highlighted by the OIG and GAO; the RACs did
- Review issues identified by the RACs in the pilot
- Perform internal audits
  - Mimic automated reviews
  - Medical record review
  - Initiate corrective actions/self disclosure?
- Coordinate with medical staff as to possible targeted issues
ASSESS EASY OPERATIONAL FIXES

- Are the Medicare coverage questionnaires completed on admission (MSP RAC)?
- Emphasize record completion
- Confirm that hospital is up-to-date re: coverage determinations
  - Particularly NCDs, which are binding on ALJs
MAINTAIN RECORDS OF ALL PREVIOUSLY AUDITED CLAIMS
RESPONDING TO A RAC AUDIT:
TEAM SHOULD REVIEW RAC FINDINGS IMMEDIATELY

- Prioritize review
- Audit the RAC audit to assure underpayments are not ignored
  - Again, do not assume RACs know the rules or used qualified staff to review the response
- Involve Physicians
- Rebuttal/Review Process
  - Not part of the appeal process
APPEAL, APPEAL, APPEAL?
RAC APPEALS PROCESS

- FIVE LEVELS OF APPEAL
  - REDETERMINATION: 120 days to file the appeal
  - RECONSIDERATION: 180 days to file the appeal
  - ADMINISTRATIVE LAW JUDGE: 60 days to file the appeal
  - MEDICARE APPEALS COUNCIL: 60 days to file the appeal
  - U.S. DISTRICT COURT: 60 days to file the appeal
DO YOU APPEAL A RAC DENIAL?

- ANY CLEAR MEDICARE RULES, GUIDANCE OR CRITERIA REGARDING THE SERVICE
- STATUS OF SUPPORTING DOCUMENTATION
- CLINICAL STAFF AVAILABILITY AND SUPPORT
- INVOLVEMENT OF OUTSIDE CONSULTANTS/ATTORNEYS TO ASSIST IN REVIEW OF DENIAL
DO YOU APPEAL A RAC DENIAL? (cont’d)

- EFFECT OF BINDING AUTHORITY ON DIFFERENT APPEAL LEVELS
  - ALJS NOT BOUND BY LOCAL COVERAGE DECISIONS, LOCAL MEDICAL REVIEW POLICIES, OR CMS PROGRAM GUIDANCE; E.G., MANUAL PROVISIONS
- AVAILABILITY OF OTHER LEGAL DEFENSES
- COST VS. BENEFIT OF THE APPEAL
  - TYPE, NUMBER, AND VALUE OF DENIALS
  - IMPACT ON SIMILAR CLAIMS
  - AGGRESSIVE APPEALS MAY MAKE PROVIDER LESS ATTRACTIVE TARGET
  - IMPACT ON COMMUNITY REPUTATION
  - COMPLIANCE REPERCUSSIONS FROM NOT CHALLENGING DENIALS
- COSTS OF RESOURCES NEEDED FOR THE APPEAL
DO YOU APPEAL A RAC DENIAL?

- DOES RAC AUDIT COMPLY WITH RAC CONTRACTUAL REQUIREMENTS?
  - EXAMPLE: NO REVIEW OF CLAIMS REVIEWED BY OTHER MEDICARE AUDITORS OR FEDERAL AGENCIES
  - EXAMPLE: CANNOT EXCEED CMS ISSUED LIMITS ON NUMBER AND FREQUENCY OF MEDICAL RECORD REQUESTS
  - EXAMPLE: DID RACs INVOLVE APPROPRIATE CLINICAL STAFF IN REVIEW
  - EXAMPLE: DID RAC APPLY CMS RULES/POLICIES OR ITS OWN SCREENING CRITERIA AND RULES
INFORMAL REVIEW PROCESS/REBUTTAL TO RAC

- PROCESS STILL BEING Refined
- POSSIBLE USE TO AUGMENT PROVIDER’S UNDERSTANDING OF THE BASIS FOR THE DENIAL
  AND IN ASSESSING WHETHER TO APPEAL
NEW DOCUMENTATION COMES TO LIGHT TO SUPPORT A CLAIM

REFERENCE ANY MEDICARE AUTHORITY SUPPORTING PROVIDER’S POSITION

PROVIDER STILL ABLE TO APPEAL, BUT USE OF REVIEW PROCESS DOES NOT AFFECT RECOUPMENT OR APPEAL TIME FRAMES
INTEREST COSTS

- IF APPEAL BEFORE RECOUPMENT, AVOID IMMEDIATE RECOUPMENT
  - *BUT*: PAY THE PIPER INTEREST LATER IF LOSE
  - SECTION 935 OF THE MMA: RECOUPMENT UNLESS REQUEST REDETERMINATION BY THE 30TH DAY AFTER THE DATE OF THE DEMAND LETTER AND UNLESS REQUEST RECONSIDERATION BY THE 60TH AFTER AN ADVERSE REDETERMINATION DECISION
- RECOUPMENT AFTER AN ADVERSE RECONSIDERATION DECISION EVEN IF APPEAL TO THE ALJ
▪ STILL COULD LOSE
  ▪ LOSE PAYMENT FOR CLAIM
  
  *PLUS*

▪ LOSE INTERNAL AND EXTERNAL RESOURCE COSTS
- CANNOT WAIT UNTIL ALJ LEVEL TO PUT TOGETHER THE APPEAL
- EARLY PRESENTATION OF EVIDENCE IN THE APPEAL PROCESS
  - CRITICAL NATURE OF RECONSIDERATION LEVEL OF APPEAL
    - ALL OF THE DOCUMENTATION THAT THE PROVIDER/SUPPLIER EXPECTS TO USE FOR THE REST OF THE APPEAL PROCESS MUST BE PRESENTED BY THE RECONSIDERATION APPEAL LEVEL
    - PROVISION OF DOCUMENTATION THEREAFTER SUBJECT TO “GOOD CAUSE” CONSIDERATIONS
GENERAL LEGAL ISSUES RELEVANT TO RAC APPEALS

- ARE RACs AUTHORIZED BY CONGRESS TO REVIEW MEDICAL NECESSITY?
ARE RAC REVIEWS UNCONSTITUTIONAL AS A RESULT OF THE CONTINGENCY FEE COMPENSATION PAID TO RACs?

- VALIDATION AUDITOR DISAGREED WITH RACS IN 40% OF CASES REVIEWED
OTHER CHALLENGES TO RAC REOPENINGS

- PROVIDER WITHOUT FAULT
- WAIVER OF LIABILITY
- TREATING PHYSICIAN RULE?
COMPLIANCE REPERCUSSIONS?

- RACs ARE TO REPORT SUSPECTED FRAUD AND ABUSE
- MMA OF 2003 DID NOT PROHIBIT INVESTIGATIONS BY CMS OF FRAUD AND ABUSE ARISING FROM A RAC OVERPAYMENT DETERMINATION
  - OTHER MEDICARE ENFORCEMENT AGENCIES WILL SEE THE DENIAL STATISTICS
ERRONEOUS OR QUESTIONABLE RAC DETERMINATIONS MIGHT BE HARDER TO CHALLENGE AT THE BACK END IF THOSE DETERMINATIONS BECOME THE BASIS OF A COMPLIANCE INVESTIGATION

- IF THE RAC FINDS OVERPAYMENTS OF A SYSTEMATIC TYPE, PROVIDER CORRECTIVE ACTIONS MERITED PARTICULARLY IF DO NOT APPEAL
- IF DO APPEAL, THERE IS A LEGAL DISPUTE OVER WHETHER ANY KNOWLEDGE OF FALSITY UNDER THE FALSE CLAIMS ACT
PREEMPTIVE ACTIONS BY THE PROVIDER

- SELF-DISCLOSURES TO THE OIG, VOLUNTARY REFUNDS AND CORRECTIVE ACTIONS TO MINIMIZE FUTURE IMPACT

SELF-DISCLOSURE AND REPAYMENT

- SHOULD A PROVIDER DISCOVER THAT IT MAY HAVE RECEIVED AN IMPROPER MEDICARE PAYMENT, MAY DECIDE TO MAKE A SELF-DISCLOSURE OR VOLUNTARY REFUND
IMPACT ON RAC AUDITS:

- RACs MAY NOT REVIEW CLAIMS THAT ARE UNDER REVIEW BY ANOTHER GOVERNMENT ENTITY
- RAC COMPENSATION IS IMPACTED BY SELF-DISCLOSURES AND VOLUNTARY REFUNDS
- VOLUNTARY REPAYMENTS
- MADE TO THE MEDICARE CONTRACTOR
- NO RAC FEES IN CERTAIN CASES
- MEDICARE PROGRAM INTEGRITY MANUAL, CHAPTER 4
OTHER CORRECTIVE ACTIONS

- Redesigning or improving internal controls
- Educating and training of relevant provider staff
- Assuring policies on documentation, coding, and billing are up to date and compliant
- Periodically monitoring claims via an internal audit to assure that documentation, coding, and billing is being done appropriately
RACs CAN EXTRAPOLATE

- RACs MUST FOLLOW SECTION 935(a) OF THE MEDICARE MODERNIZATION ACT OF 2003
- CMS ENVISIONS A RAC USING EXTRAPOLATION IN CASES WHERE THERE WAS EVIDENCE OF A SUSTAINED OR HIGH LEVEL OF PAYMENT ERROR OR DOCUMENTED EDUCATION INTERVENTION BY THE MEDICARE CONTRACTOR
And let’s not forget the other CMS Improper Payment Review Entities

MAC: Medicare Administrative Contractor
ZPIC: Zone Program Integrity Contractor
CERT: Comprehensive Error Rate Testing Program
PSC: Program Safeguard Contractor
OIG: Office of Inspector General
QIO: Quality Improvement Organizations
QUESTIONS?

Kathy Drummy
Davis Wright Tremaine LLP
865 S. Figueroa St. 24th Floor
Los Angeles, CA 90017
(213) 633 – 6800

kathydrummy@dwt.com

www.dwt.com