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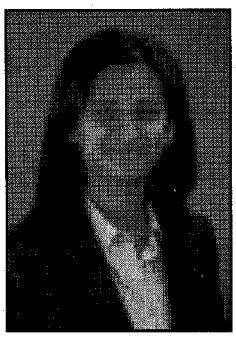

One major piece of health care reform includes reforming the Medicare Program, one of the largest government programs in history. A January 2008 report from the Office of Management and Budget concluded that the Medicare Program is one of the top three government programs with improper payments. Of the 1.2 billion claims processed in 2007, improper payments accounted for Medicare costs of $10.8 billion. The Recovery Audit Contractor Program (RAC Program) was implemented as the most cost effective program to address such improper payments. While some states have already been injected into RAC review, it is still unclear when each state and providers or suppliers will come under review. This article attempts to identify some of the key elements that providers and suppliers need to consider prior to and throughout the RAC review process.

I. THE BEGINNINGS OF THE RAC PROGRAM

Section 306 of the Medicare Modernization Act of 2003 (MMA) charged the U.S. Department of Health and Human Services (HHS) with the task of designing a program to identify and correct past improper Medicare payments for services under both Part A and Part B.In 2005, the Recovery Audit Contractor Demonstration Project (Project) began its pilot program as a response to the MMA legislation. Both Claim Recovery Audit Contractors and Medicare Secondary Payer Recovery Audit Contractors (collectively RACs) were utilized to identify improper Medicare payments.[1]

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1. CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, *The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration* 1 (2008), *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf. "Claim RACs" reviewed claims to identify

The MMA legislation required that the Project cover at least two states that are among the states with the highest per capita utilization rates of Medicare services. California, Florida and New York were the first states that were included in the Project until 2007, when the Project expanded into Massachusetts, South Carolina and Arizona. At the completion of its three year run, the RACs were able to correct roughly $1.03 billion in Medicare improper payments.[2] Over 96% of these payments were overpayments collected from providers, while the remaining four percent were underpayments that were repaid to providers.[3] In addition, the Claim RACs collected a significant amount more ($980 million) than the MSP RACs ($12.7 million).[4] Specifically, of the inpatient hospital claims reviewed, thirty-six percent of all improper claims were due to incorrect coding, forty-one percent due to medically unnecessary setting, and eight percent due to failure to submit sufficient documentation.[5] The cost of the Project as compared to the amount returned to the Medicare Trust Funds served as the catalyst for implementing the RAC Project as a permanent and nationwide program.

II. THE PERMANENT RECOVERY AUDIT CONTRACTOR PROGRAM

Section 302 of the Tax Relief and Health Care Act of 2006 (TRHCA) established the permanent RAC Program and required that it be implemented no later than 2010. The TRHCA requires HHS to implement several elements in carrying out the RAC Program.

A. RAC Vendors

Four RAC vendors were chosen to implement and carry out the permanent program. Diversified Collection Services, Inc. of Livermore, California was chosen for Region A (including Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Deleware and New York). CGI Technologies and Solutions, Inc. of Fairfax, Virginia was chosen for Region B (including Wisconsin, Michigan, Indiana and Minnesota). Connolly Consulting Associates, Inc. of Wilton, Connecticut is the vendor for Region C (including New Mexico, South Carolina, Florida, Texas and

improper payments based on medical necessity criteria, incorrect coding of services, submission of documentation to support a claim and other claims not in conformance with Medicare regulations. "MSP RACs" attempted to identify payments improperly made when Medicare has been paid by a different health insurance company.

2. *Id.* at 14-15.
3. *Id.*
4. *Id.*
5. *Id.*

Colorado). Finally, HealthDataInsights, Inc. of Las Vegas, Nevada will represent Region D (including California, Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona). All RACs are compensated on a contingency fee basis, based on the principal amount of collection or amount paid back to a supplier or provider. The contingency fees range from 9% to 12.5% depending on the RAC vendor.

B. Types of Reviewable Issues

RACS will only review issues that have been approved for auditing. Regions B, C and D have been approved for issues including excessive units of blood transfusions, IV hydration therapy and bronchoscopy services. Further, Regions C and D have been approved for untimed codes, injections, pediatric codes exceeding age parameters, and once-in-a-lifetime procedures.

C. Types of Reviews

RACs conduct two categories of reviews under the TRHCA. First, RACs conduct "automated reviews." An automated review is a review of claims data without a review of records that can only be conducted when there is certainty that a claim yields an overpayment. Certainty that the claim contains an overpayment can be found when the overpayment decision is based on a provider's failure to respond to a RAC medical record request, a clear policy (i.e., statute, regulation, National Coverage Determination, interpretive manual provisions, or Local Coverage Determinations) or a clinically unbelievable service. The second type of review that RACs will conduct is a "complex review." A complex review is a review of medical records when there is no certainty but a high probability that a claim includes an overpayment. Under a complex review, the number of records that RACs can request is limited.

Medicare Part A billers such as inpatient hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and hospices will only be obligated to provide medical records within ten percent of the average monthly Medicare claims but not to exceed a maximum of 200 records per forty-five days. Other Part A billers such as outpatient hospitals and home health will be obligated to provide medical records within one percent of average monthly Medicare services but not to exceed a maximum of 200 records per forty-five days. Regarding physicians, the request is limited based on the number of physicians in the practice. Finally, for Medicare Part B billers other than physicians, RACs are limited to requesting one percent of average monthly Medicare services per forty-five days. In all cases, however, RACs may request permission to exceed the cap.

D. Look-back Period

Under the Project, RACs were not prohibited from reopening claims up to four years following the initial payment date. Under the permanent RAC program, all regions have a three-year maximum look-back period and RACs in no case may review claims paid prior to October 1, 2007.

E. Contractor Medical Director

The Project did not require RACs to employ a physician medical director or coding expert when conducting coding or coverage reviews of medical records requested from the Medicare provider or supplier. However, under the permanent RAC program, the RACs are required to employ a contractor medical director who is a doctor of medicine or doctor of osteopathy and to interpret Medicare policy.

III. RAC DENIALS AND THE MEDICARE APPEALS PROCESS

Where a provider or supplier receives a claim denial or where a RAC determines that there was an overpayment, Medicare appeal regulations, 42 C.F.R. §405.900 *et seq.*, afford a provider or supplier the right to appeal such determinations. Involving consultants or legal counsel early in the process will ensure proper navigation of the procedural obligations.

A. Level 1 Redetermination

Redetermination is the first level of appeal in the Medicare appeal process. Providers have 120 days to request an initial redetermination in writing. There is no amount in controversy requirement.

B. Level 2 Reconsideration

Reconsideration is the second level of appeal in the Medicare appeal process. A Qualified Independent Contractor Review (QIC) reviews the reconsideration appeal. This level of appeal must be filed within 180 days of receiving notice of the redetermination decision. There is no requirement of an amount in controversy. Providers must submit a full and early presentation of evidence in the reconsideration stage.

C. Level 3 Administrative Hearing

A provider is given the opportunity to appeal to an Administrative Law Judge (ALJ) and is entitled to a hearing at the third appeal level. The request for an ALJ hearing must be filed within sixty days following receipt of the QIC's reconsideration decision. The request must satisfy an amount in controversy of $120. An ALJ hearing may be conducted by telephone,

video-teleconference or in-person.

D. Level 4 Medicare Appeals Council Review (MAC)

The fourth level of review is the MAC Review. A MAC Review request must be filed within sixty days following receipt of the ALJ's decision. The MAC Review request must identify and explain the specific parts of the ALJ decision with which it disagrees.

E. Level 5 Federal District Court

The last opportunity to appeal a decision is judicial review in federal district court. A federal district court review request must be filed within sixty days of receipt of the MAC's decision. An amount in controversy of $1,180 must be met before judicial review may begin. Findings of fact by the Secretary of HHS are deemed conclusive if supported by substantial evidence.

IV. CONCLUSION

Greater governmental scrutiny on identifying improper payments under the Medicare program mandates that providers and suppliers pay close attention to billing practices and be prepared to respond to RAC audits. Further, compliance policies should be updated to reflect RAC review requirements. It behooves providers and suppliers to contact their counsel and consultants to gear up for RAC reviews.