

Frank Fedor

# recovery audit contractors “RAC” up another challenge for providers

## **A new Medicare demonstration project is under way in three states**

in which recovery audit contractors are reviewing old Medicare claims to discover overpayments and demand their repayment from providers. The RACs, which will review claims over the next three years, will be paid on the basis of a percentage of the overpayments they recover. If they recover a fraction of what Medicare estimates it overpays each year, the impact upon providers will be large and the program will likely be extended nationwide.

## **AT A GLANCE**

Old Medicare claims in California, Florida, and New York are now subject to review by recovery audit contractors. To deal with these audits, providers should:

- > Identify who within their organization will receive RAC communications
- > Review their practices in addressing government audits and claims of overpayment
- > Consider the compliance implications of the RAC's findings of overpayments

## **A \$19 Billion Annual Overpayment Problem**

The purpose of the RAC project is to recover the large amounts of overpayments annually estimated for the Medicare program. From 1996 through 2002, the Office of Inspector General published annual Medicare fee-for-service error rates. These showed net projected overpayments (overpayments minus underpayments) of \$23.2 billion in 1996 and a general trend down to \$13.3 billion in 2002.

In 2003, Michael O. Leavitt, secretary of the Department of Health and Human Services, established two programs to more comprehensively monitor the accuracy of Medicare fee-for-service payments: the Comprehensive Error Rate Testing program and the Hospital Payment Monitoring program. Leavitt claims these programs use a larger sample size and are much more precise than the methods earlier used by the OIG. Under these new methodologies, Medicare net overpayments were \$19.6 billion for 2003 and \$19.8 billion for 2004. Note that the use of the new methodology resulted in a \$6 billion-plus increase in estimated net overpayments from 2002 to 2003 and 2004.

Obviously, if RACs were operating nationwide and could identify Medicare fee-for-service net overpayments of even half of \$19 billion a year, the impact on providers would be huge.

## **Statutory Basis**

RACs were created at the direction of Congress under section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

A provider may want to take a more aggressive approach in auditing some of the same claims the RAC audits to ensure that all underpayments are found and to confirm the accuracy of the RAC's findings of overpayments.

Section 306 directs the HHS secretary to conduct a demonstration project to show the use of recovery audit contractors in identifying payment errors under the Medicare program.

The project, announced by the Centers for Medicare and Medicaid Services on March 31, is to last for no longer than three years and is to cover at least two states that are among those with the highest per capita utilization rates of Medicare services. The contractors may not be current fiscal intermediaries or carriers. Preference must be given to contractors who have demonstrated proficiency for cost control or recovery audits with private insurers, health plans, or providers. The HHS secretary must submit a report to Congress within six months after the program ends.

Two other aspects of section 306 are most relevant to providers. First, under section 306(e), the recovery of an overpayment to a provider by an RAC does not necessarily prohibit the secretary or attorney general from investigating and prosecuting allegations of fraud or abuse arising from such overpayment. Second, under section 306(a)(1), RACs may be paid on a contingency basis. As implemented by CMS, RACs are required to identify both overpayments and underpayments, but they are paid only a percentage of the overpayments they recover. In information sessions, CMS says the amount of underpayments to providers identified does not reduce the amount of

overpayments upon which the RAC is paid, but the obvious incentive is to focus resources on identifying overpayments.

#### **How the Demonstration Project Will Work**

RACs are categorized into those that will pursue Medicare secondary payer overpayments and those that will pursue non-MSP overpayments. In November 2004, CMS posted two "statements of work" that give some detail about how RACs are to operate.


During the three-year demonstration, RACs will pursue only overpayments occurring in California, Florida, and New York. Nevertheless, a provider not located in one of these three states may have some of its claims subject to RAC review because the non-MSP RACs are permitted to attempt to identify overpayments made on claims submitted to carriers and intermediaries in any of these states or to durable medical equipment regional carriers for services provided to beneficiaries with a primary residence in one of these three states.




*Impact on providers.* Providers are likely to see little impact from the MSP RACs. The MSP RACs will audit only group health plan claims—not liability, no-fault, or workers' compensation claims. Demands for payment will be made only to employers, not to providers.

On the other hand, providers will be affected by the non-MSP RACs, which will seek to identify overpayments and underpayments to providers. The parameters of what these RACs may and may not pursue are somewhat complex. In general, non-MSP RACs may attempt to identify over- and underpayments that result from incorrect payment amounts and noncovered, not reasonably necessary, incorrectly coded, or duplicate services. Non-MSP RACs may not pursue overpayments on services under a non-Medicare fee-for-service program (such as a Medicare managed care, Medicare drug card, or drug benefit program), resulting from the cost report settlement process, or resulting from the miscoding of evaluation and management services (except services resulting from E&M services that are not reasonable and necessary or violations of Medicare's global surgery payment rules that involve E&M services).

Non-MSP RACs will have access to CMS's national claims history data initially for FY02 through FY04, and then updated monthly. CMS will maintain a claims database to prevent overlap in the pursuit of the same overpayments between RACs and CMS, CMS's contractors, the Department of Justice, and the OIG.


 *Types of reviews.* Non-MSP RACs will conduct both automated and complex reviews. An automated review will involve the application of an RAC's proprietary software to the national claims history data furnished by CMS and may be used only when there is certainty that the service was not covered or was incorrectly coded, a duplicate payment, or otherwise an overpayment. A complex review requires the review of copies of medical records. Providers should note that if an RAC does not receive copies of medical records within 45 days of its request, the RAC is authorized to find that the claim was overpaid.

Section 935 of the MMA prohibits the use of random claim selection for any purpose other than to establish an error rate. For this reason, CMS prohibits a non-MSP RAC from randomly selecting cases for which it requests copies of medical records. Instead, the RAC is to use data analysis to identify claims most likely to contain overpayments in a process CMS calls "targeted review." An RAC may not target solely high-dollar claims, but must identify other information that leads the RAC to believe the claim is likely to contain an overpayment.

 *Communication of results.* Non-MSP RACs must communicate to the provider only the overpayments that result from automated reviews and all results of complex reviews whether they result in an overpayment or not. Non-MSP RACs must follow all Medicare statutes, regulations, policies (including local coverage determinations), and local coverage/coding articles. The RAC must also communicate to the provider which coverage/coding/payment policy or article was violated to result in the overpayment, and notify the provider of its appeal rights.

The notification of overpayments will take the form of a demand letter. If repayment is not made, the matter may be referred to CMS for offset, or after 180 days to the Department of the Treasury for collection.

RACs have no authority to compromise claimed overpayments. They do have limited authority to agree to a payment plan.

 *Appeals.* Providers have full appeal rights as they would if CMS or one of its contractors had identified the overpayment. Once the provider appeals, the RAC must stop pursuing the claim. Interest continues to accrue throughout the appeal process.

### Practical Impact of RACs

Providers in California, Florida, and New York need to consider several steps in addressing RAC audits.

First, they should identify who within the organization will receive RAC communications and prepare them to deal with RAC requests or communications of payment errors. The individuals currently receiving information from Medicare will, by default, also receive information from the RAC. Contact information with the RAC can be customized so communications come to staff trained to deal with RACs and their special deadlines.

Second, the potential larger scale of overpayments both in number of claims and total value of dollars that will result from RAC audits make it prudent for providers to review their practices in addressing government audits and claims of overpayment. A provider may want to take a more aggressive approach in auditing some of the same claims the RAC audits to ensure that all underpayments are also found and to confirm the accuracy of the RAC's findings of overpayments. Providers should also carefully review their process for deciding whether to appeal notices of overpayment they currently receive from Medicare. There may be current cost-benefit calculations that do not apply to the larger volume and value of overpayment notices that an RAC may send, and the current staff may not be prepared to make a large volume of appeal decisions within the short deadlines allowed. Because of the larger amounts at stake, more resources may be needed in the early stages of the appeal process to develop the factual record that sets the foundation for the issues that can be appealed to federal court.

### MEDICARE FEE FOR SERVICE FAST FACTS (FY03 AND FY04)

**Total payments issued**  
FY03: \$199.1 billion  
FY04: \$213.5 billion

**Gross error rate**  
FY03: 10.8 percent  
FY04: 10.1 percent

**Net error rate**  
FY03: 9.8 percent  
FY04: 9.3 percent

© 2005 Computrix Management Center, Inc. Laserfiche is a trademark of Computrix Management Center, Inc. All rights reserved.

## Collect and Protect



### Safeguard your revenue cycle with secure document management.

Regulatory demands. Unpaid care. Tight budgets.

Rise to the challenges with Laserfiche document management solutions. Boost efficiency from the front desk to the back office and improve cash flow. All while supporting HIPAA compliance and keeping information secure.

Learn how at a free Webinar. Register at [www.laserfiche.com/hfm](http://www.laserfiche.com/hfm) or call 866-888-9832.

Run Smarter<sup>SM</sup>

**Laserfiche**

## MEDICARE/MEDICAID

Third, the provider must carefully consider the compliance implications of the RAC's findings of overpayments. For example, if the RAC finds overpayments of a certain systematic type for 2003, the provider should examine whether the same type of systematic overpayment occurred in 2004 and beyond. The provider may have excellent defenses to claims of fraud or violations of the False Claims Act in not discovering that these overpayments had occurred in 2003, but these defenses may weaken in defending the same overpayments made in 2004 and beyond if the provider did nothing to investigate and correct the situation after receiving the RAC notification of these overpayments.

On the other hand, if the provider disputes the RAC's findings of overpayments, then it is that much more important to timely appeal the overpayments. The exercise of appeal rights may show the existence of a legal dispute and the absence of the statutory element of "knowledge" of falsity needed to prove a violation of the False Claims Act. A failure to timely appeal notifications of overpayments can arguably have the opposite effect.

Many of these same issues should be considered by providers that do business in multiple states that include one of the RAC states or with CMS carriers and intermediaries located in an RAC state. An overpayment in a facility in an RAC state may suggest a review of whether it is a companywide issue or otherwise occurring in facilities in non-RAC states. For the same reason, although providers outside of California, Florida, and New York will not feel an immediate impact from RACs, these providers should nevertheless monitor how the RACs operate and what the RACs find to see whether they should consider investigating a similar type of overpayment or adjust some aspect of their practices.

Very interesting times are just around the corner. ●

Frank Fedor, JD, is a partner, Murphy Austin Adams Schoenfeld, LLP, Sacramento, Calif., and a member of HFMA's Northern California Chapter. Questions or comments about this article may be sent to him at [ffedor@murphyaustin.com](mailto:ffedor@murphyaustin.com).