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## RAC Preparation – 7 Key Steps and Best Practices



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**A**fter a short delay, the Department of Health and Human Services' (DHHS) roll-out of the recovery audit contractor ("RAC") program will be implemented in all states by the year 2010. As of March 1, 2009, the four national RACs<sup>1</sup> have commenced information requests in approximately two-thirds of the states. This article provides a brief overview of the demonstration program, the common mistakes providers make in their claims, steps providers should take to prepare for a RAC audit, and post-audit best practices.

## I. RESULTS OF THREE-YEAR DEMONSTRATION PROGRAM

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), directed DHHS to conduct a 3-year demonstration using RACs to detect and correct improper payments in the Medicare FFS program (the "Demonstration Program"). The purpose of the Demonstration Program was to (i) detect and correct past improper payments in the Medicare fee-for-services ("FFS") program; and (ii) provide information to the Centers for Medicare and Medicaid Services ("CMS") and Medicare contractors that could help protect the Medicare Trust Funds by preventing future improper payments which would ultimately lower the Medicare FFS claims payment error rate.<sup>2</sup> The Demonstration Program focused on providers in Massachusetts, California, South Carolina, Florida, and New York and examined their claims from October 1, 2001 through September 31, 2005.

As of March 27, 2008, the RACs had succeeded in correcting more than \$1.3 billion of improper Medicare payments.<sup>3</sup> Improper payments are comprised of both overpayments and underpayments. Of this total, approximately ninety-six percent (96%), or \$992.7 million, of these improper payments were the result of overpayments collected from providers, while the remaining four percent (4%), or \$37.8 Million were underpayments repaid to providers.<sup>4</sup>

Most overpayments (85%) were collected from inpatient hospital providers, 6% from inpatient rehabilitation facilities, and 4% from outpatient hospital providers.<sup>5</sup>

The Demonstration Program showed that improper payments generally occur in four (4) different situations:

1. Payments are made for services that were not medically necessary;
2. Payments are made for services that are incorrectly coded;
3. Providers fail to submit documentation to support the services provided or fail to submit enough documentation to support the claim; and
4. Other errors are made (i.e., the claim is submitted twice and ultimately paid twice).<sup>6</sup>

Overall, CMS views the Demonstration Program as highly successful in removing improper payments. Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and expanded the program to all 50 states by 2010.

## II. PREPARATION PRIOR TO AUDIT

Based on the success of the Demonstration Program, providers should not wait until the RAC program reaches their respective state or their audit commences to begin preparing for a RAC audit. The Demonstration Program has provided tools that, in light of the ongoing RAC program expansion, can be used by providers to form a plan of action. Specifically, providers should consider the following proactive steps in preparing for a RAC audit.

1. **Compliance Committee.** Form a compliance committee to identify potential overpayments and develop a corrective action plan to reduce the risk of future overpayments. Providers may consider forming interdisciplinary teams from compliance, risk management, finance, medical records and legal departments.

1 Diversified Collection Services, Inc. in Region A; CGI Technologies and Solutions, Inc., in Region B; Connolly Consulting Associates, Inc. in Region C; and HealthDataInsights, Inc. in Region D.

2 *The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration*, The Centers for Medicare and Medicaid Services, January 2009.

3 *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, The Centers for Medicare and Medicaid Services, June 2008.

4 Id.

5 Id.

6 Id.

2. **Medical Record Documentation.** Ensure that medical records contain appropriate documentation. Proper documentation can be helpful evidence that a procedure was medically necessary if such claim for payment was ever challenged. The RACs are entitled to look back at the prior three (3) years' billing records, but in no case prior to October 1, 2007.<sup>7</sup> Therefore, providers, while reviewing and correcting current medical records, should also review those medical records dating October 1, 2007 and going forward for a three year period.
3. **Medicare Rules.** Conduct internal assessments to ensure that submitted claims meet all Medicare coverage and payment rules. The majority of overpayments occur when health care providers submit claims that do not meet Medicare's coding or medical necessity policies.<sup>8</sup> Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."<sup>9</sup> Documentation in a patient's medical record must support the diagnosis information sent on the claim for reimbursement. Thus, the RACs will generally examine the "medical necessity" of past procedures and then review the provider's records to ensure that the records support the provided medical treatment.
4. **Past Errors.** Review the CMS website as well as the individual RACs' websites<sup>10</sup> to identify any patterns of denied claims. A provider should assess whether these problems or practices occur within its own practice or facility. For example, a surgical procedure in the wrong setting (classified as medically unnecessary) has resulted in \$88 million dollars in overpayments to inpatient hospitals.<sup>11</sup> The chart below summarizes the percentage of the total overpayments collected during the Demonstration Program by type of error and provider type:

Error Type	Inpatient Hospital	Inpatient Rehab Facility	Skilled Nursing Facility	Out-patient Hospital	Physician	Ambulance/Lab/ Other	Durable Medical Equipment	TOTAL
Medically Unnecessary	34.5%	5.63%	0.26%	0.47%	0%	0%	0%	40.86%
Incorrectly Coded	30.48%	0%	0.62%	2.44%	1.05%	0.065	0%	34.66%
Insufficient Documentation	6.63%	0.44%	0.48%	0.11%	0%	0%	0.09%	7.76%
Other	12.57%	0%	0.41%	1.22%	1.44%	0.45%	0.63%	16.72%
<b>TOTAL</b>	<b>84.19%</b>	<b>6.07%</b>	<b>1.765</b>	<b>4.255</b>	<b>2.50%</b>	<b>0.51%</b>	<b>0.72%</b>	<b>100.00%</b>

Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, June 2008.

7 CMS RAC Status Document; FY 2007, The Centers for Medicare & Medicaid Services, February 2008.

8 CMS Announces New Recovery Audit Contractors to Help Identify Improper Medicare Payments, The Centers for Medicare and Medicaid Services Press Release, Oct. 6, 2008.

9 42 U.S.C. 1395y(a)(1)(A).

10 Diversified Collection Services, Inc.: <http://www.dcswins.com/dcs/index.htm>; CGI Technologies and Solutions, Inc.: <http://www.cgi.com/web/en/home.htm>; Connolly Consulting Associates, Inc.: <http://www.connolly-consulting.com/home.aspx>; and HealthDataInsights, Inc.: <http://www.healthdatainsights.com/>.

11 The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, June 2008.

The chart below summarizes the service with the greatest overpayment in each provider type based on the Demonstration Program's results:

Provider	Description of Item or Service	Amount Collected less Cases Overturned
<b>Inpatient Hospital</b>	Surgical procedures in wrong setting (medically unnecessary)	\$88 Million
<b>Inpatient Rehab Facility</b>	Services following joint replacement surgery (medically unnecessary)	\$37 Million
<b>Outpatient Facility</b>	Neulasta (medically unnecessary)	\$6.5 Million
<b>Skilled Nursing Facility</b>	Physical therapy and occupational therapy (medically unnecessary)	\$6.8 Million
<b>Physician</b>	Pharmaceutical injectables (medically unnecessary)	\$5.8 Million
<b>Lab/Ambulance/Other</b>	Ambulance services during a hospital inpatient stay (other error type)	\$2.9 Million
<b>Durable Medical Equipment</b>	Items during a hospital inpatient stay or SNF stay (other type)	\$4.8 Million

Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, June 2008.

5. **Employee Education.** Inform and educate employees on the audit process. Conduct monthly meetings in which any recent developments as well as the status of the audit are discussed. Keeping these individuals informed of the process and the consequences of documentation and billing errors will help the audit moving smoothly as well as streamline the billing process in the future. Many of the RAC denials involve hospital admissions that were not supported.<sup>12</sup> Physicians should be informed and educated on the provider's admission process, as well as how to document all procedures and exams correctly.
6. **Point Person.** Select a point person to handle all RAC requests and ensure that such individual receives communications and responds to communications in a timely manner. It is important that this individual establishes a line of communication with the regional RAC. RACs are required to communicate via email, phone, letters, and in-person.<sup>13</sup> Cultivating a working relationship with the RAC will help smooth the process and ensure timely communication. This is especially true considering there are short time frames for responses once a provider receives a communication from the RAC. For example, once a provider receives a request for medical records, it has 45 days to respond.<sup>14</sup>
7. **Counsel.** Identify and engage independent counsel to provide assistance throughout the process as well as to assist in filing any appeals.

Providers should consider implementing the above practices as soon as possible. These proactive measures are intended to facilitate the RAC audit and minimize the burden and strain, both financial and organizational, on providers once the audit commences.

<sup>12</sup> *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, The Centers for Medicare and Medicaid Services, June 2008.

<sup>13</sup> *Statement of Work for the Recovery Audit Contractor Program*, The Centers for Medicare & Medicaid Services.

<sup>14</sup> *Medicare Program Integrity Manual; Chapter 3: Verifying Potential Errors and Taking Corrective Action*, The Centers for Medicare & Medicaid Services.

### III. BEST PRACTICES DURING AND AFTER AUDIT

1. **Organization.** As a provider's audit commences, its administrative personnel need to process the correspondence and request from the RAC promptly and efficiently. All such letters, requests for information, findings, appeals, or any other requests must be promptly delivered to the designated point person and immediately answered. Once an audit has begun, the time-frame within which the provider may act is limited and time should not be lost tracking down the appropriate personnel as correspondence is received.<sup>15</sup> Establishing a working relationship with the RAC should also facilitate this process.
2. **Review Findings.** It is imperative that providers scrutinize the RAC's findings to determine whether or not to appeal or challenge any of the RAC findings. Thus far, providers have successfully appealed 7.6% of all RAC overpayment determinations.<sup>16</sup> A provider should perform a shadow audit with the RAC to ensure the findings are correct, respond to any questions and clarify any issues as they arise. Should a provider disagree with the RAC's findings, an appeal must be filed as soon as possible, as the time period to appeal a RAC determination is relatively short. The below chart provides a brief overview of the timeframes associated with each level of appeal in the RAC appeals process:

Level of Appeal	Days a Provider Has to File	Days Until Issuance of Decision
Redetermination by the Fiscal Intermediary	120	60
Reconsideration by a Qualified Independent Contractor	180	60
Administrative Law Judge Hearing	60	90
Medicare Appeals Council Review	60	90
Judicial Review in U.S. District Court	60	--

3. **Assess Corrective Action.** Finally, providers should determine what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future. The preceding steps should have identified most, if not all, of the weaknesses in the existing medical records and procedures. Providers should begin educating the practitioners and billing and coding staff on these corrective actions as soon as possible. Conducting seminars for physicians, nurses, and staff will assist in the education aspect and conducting internal mini-audits will ensure that the corrected steps are being implemented.

The bottom line: providers should begin preparation as soon as possible. Valuable time and resources may be saved if a provider is in the position to respond to the RAC's requests as soon as possible and if any overpayments or improper billing practices are identified and corrected prior to the audit. The Demonstration Program has provided vital information and results that, taken into consideration, will help minimize the provider's number of denied payments in its upcoming audit as well as reduce the operational strain that such an audit can place on a provider.

<sup>15</sup> For a copy of the McGuireWoods white paper, "A Primer on RAC Appeals, please contact Elissa Moore at [emoore@mcguirewoods.com](mailto:emoore@mcguirewoods.com), Brent Rawlings at [brawlings@mcguirewoods.com](mailto:brawlings@mcguirewoods.com) or Lainey Gilmer at [egilmer@mcguirewoods.com](mailto:egilmer@mcguirewoods.com)

<sup>16</sup> The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, The Centers for Medicare and Medicaid Services, January 2009.