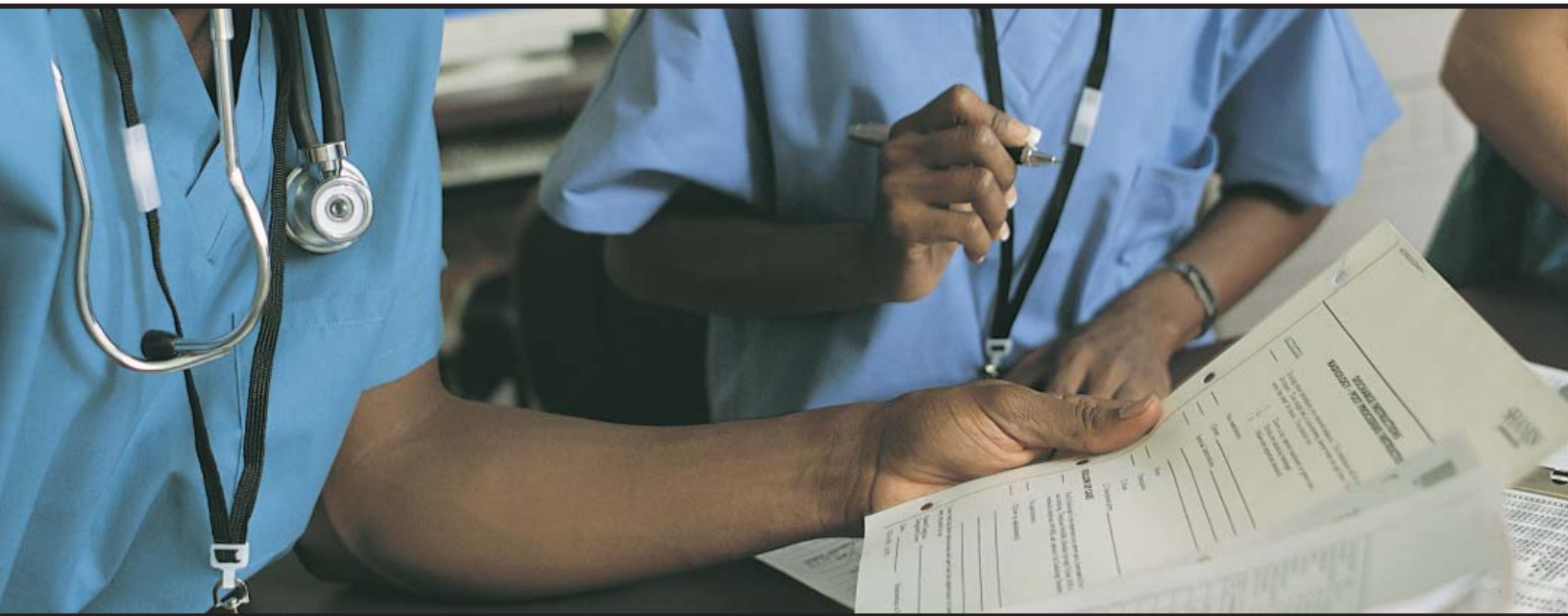


# Medicare Recovery Audit Contractors (RACs): What Providers Need to Know and How to Prepare



**McGUIREWOODS**  
*Relationships That Drive Results*

**R. Brent Rawlings, JD, MHA, FACHE**  
804.775.1126 | rbrawlings@mcguirewoods.com

One James Center | 901 East Cary Street  
Richmond, Virginia 23219-4030

[www.mcguirewoods.com](http://www.mcguirewoods.com)

**I. Introduction.** On March 28, 2005, the Centers for Medicare and Medicaid Services (“CMS”) introduced a new demonstration project that would use Recovery Audit Contractors (“RACs”) to assist Medicare in identifying improper payments made to healthcare providers and suppliers not detected through existing program integrity efforts.<sup>1</sup> The demonstration is now complete and proved to be successful in returning millions of dollars in overpayments to the Medicare Trust Fund. Convinced of the value of RACs to the Medicare Program, Congress passed into law Section 302 of the Tax Relief and Health Care Act of 2006, which mandates extension and expansion of RACs nationwide by no later than January 1, 2010.<sup>2</sup>

The demonstration project was conducted in three states - California, Florida, and New York. CMS’ current expansion strategy for the permanent recovery audit contractor program has RACs operating in twenty-three states by March 1, 2009 and the remaining twenty-seven states and the District of Columbia beginning August 1, 2009 or later.<sup>3</sup> This article will provide a brief overview of the RAC process and a discussion of what steps providers can take to prepare for the expansion of the permanent recovery audit contractor program.



**II. Background on RACs.** Section 306 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 directed the Secretary of Health and Human Services (the “Secretary”) to establish a demonstration program for the use of “recovery audit contractors” in identifying underpayments and overpayments and recouping those overpayments identified.<sup>4</sup> These RACs were intended to supplement the identification of overpayments by Medicare Affiliated Contractors (“MACs”), as it had previously been determined that MACs only examined a small percentage of claims during medical review.<sup>5</sup> The demonstration project included two types of RACs: 1) Medicare Secondary Payer (“MSP”) RACs, and 2) non-MSP claims and activity RACs. MSP RACs are responsible for identifying situations where Medicare should not have been the primary payer.<sup>6</sup> Non-MSP claims and activity RACs (“Claim RACs”) are responsible for reviewing claims and medical records to identify overpayments and underpayments for Medicare claims (*i.e.*, not overpayments and underpayments for cost reporting activities). The focus of this paper is non-MSP claims and activity RACs and the large financial impact they are expected to have on the Medicare program.<sup>7</sup>

Section 302 of the Tax Relief and Health Care Act of 2006 will have the effect of continuing operation of Claim RACs in the demonstration project states and expanding their operation to all states by no later than January 1, 2010. As discussed previously, the current expansion strategy could result in Claim RACs

- 1 CMS Press Release, Demonstration to Work Towards Assuring Accurate Medicare Payments, March 28, 2005.
- 2 Pub. Law 109-432, Dec. 20, 2006, codified at 42 U.S.C. § 1395ddd(h).
- 3 Available online at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp). By October 1, 2008, the following states were expected to have operating RACs: Arizona, Colorado, Florida, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New York, New Mexico, North Dakota, Rhode Island, South Carolina, South Dakota, Utah, Vermont, and Wyoming. By March 1, 2009, the following states are expected to have operating RACs: California, Nevada, Oklahoma, and Texas. Beginning August 1, 2009 or later, the remaining states and the District of Columbia are expected to have operating RACs.
- 4 See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 306, Public Law 108-173, Dec. 8, 2003.
- 5 See CMS, MedLearn Matters Number SE0469.
- 6 *Id.* For more information on MSP RACs, see generally Medicare Secondary Payer Manual, Pub. 100-5, Chapter 8.
- 7 See CMS RAC Status Document, Fiscal Year 2007, Status on the Use of Recovery Audit Contractors in the Medicare Program, page 12.

operating in all 50 states and the District of Columbia as early as August 1, 2009.<sup>8</sup> Claim RACs established pursuant to Section 302 will look and act substantially the same as their demonstration project predecessors, with a few exceptions as noted below. Claims reviewed by Claim RACs may include Part A, Part B, physician, hospital, skilled nursing facility, inpatient rehabilitation, hospice, home health, clinical laboratory, and durable medical equipment, prosthetics, orthotics, and supplies (“DMEPOS”) claims.<sup>9</sup>

Claim RACs are paid on a contingency basis, retaining a percentage of the amount recovered for overpayments and, as of March 1, 2006, Claim RACs receive an equivalent percentage for all underpayments identified.<sup>10</sup> CMS status documents for Claim RAC activity demonstrate that the program is resulting in significant returns to the Medicare Trust Fund: \$54.1 million in Fiscal Year 2006 - a 373% return on investment<sup>11</sup> and \$247.7 million in Fiscal Year 2007 – a 318% return on investment<sup>12</sup>.

**III. How Claim RACs Work.** The claims review process employed by Claim RACs is relatively straightforward. The Claim RACs receive a data file from CMS containing National Claim History data about claims that have been processed by the MAC in the state in which the RAC operates, followed by monthly updates. Claim RACs then analyze this data to identify underpayments and overpayments.

**A. Claims Included in Review**

Under Section 302, Claim RACs may not retrospectively review claims for a period of more than four years prior to the current Fiscal Year.<sup>13</sup> The Request for Information and Draft Statement of Work for RACs (the “SOW”),<sup>14</sup> which establishes initial standards for the permanent Claim RAC contractors under the expansion plan, reduces the retrospective review period to not more than three years past the date of the initial determination made on the claim. In addition, the SOW provides that Claim RACs are not permitted to review claims recently paid within the prior twelve-month period<sup>15</sup> and Medicare managed care claims and Part D claims are excluded from Claim RAC review. Also excluded from Claim RAC review are physician evaluation and management services, claims previously reviewed by another Medicare contractor or claims that are part of an ongoing post-payment medical review investigation, and claims that are part of a fraud or benefit integrity investigation or potential criminal investigation.<sup>16</sup>

**B. Automated and Complex Claim Review**

Claim RACs identify overpayments and underpayments using a combination of automated and complex claims reviews. Automated claims reviews, which involve Claim RAC analysis of claims using proprietary

8 See CMS Expansion Strategy, available online at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp).

9 For purposes of this paper, physician, provider, and supplier are all collectively referred to here as “providers” or “provider,” except where otherwise specified.

10 See CMS, MedLearn Matters Number SE0617.

11 CMS RAC Status Document, Fiscal Year 2006, Status on the Use of Recovery Audit Contractors in the Medicare Program, p. 18.

12 CMS RAC Status Document, Fiscal Year 2007, Status on the Use of Recovery Audit Contractors in the Medicare Program, p. 12.

13 42 U.S.C. § 1395ddd(h)(4)(b).

14 Draft Statement of Work for the Recovery Audit Contractors, available online at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac).

15 For example, on June 1, 2008, the RAC may not review claims with a claim process or claims paid date between June 1, 2007 and May 31, 2008.

16 See Draft Statement of Work for the Recovery Audit Contractors, available online at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac), pps. 6-8.

software, *do not* require medical record review and involve simple objective determinations, such as improper payment for non-covered services or coding errors.<sup>17</sup> Any automated review must have a clear policy, such as a statute regulation or National Coverage Determination that serves as a basis for the overpayment, must be based on a medically unbelievable service, or occur when no timely response is received in response to a medical record request letter.<sup>18</sup>

Complex claims reviews *do* require a review of medical records by the Claim RACs.<sup>19</sup> For complex claim reviews, the Claim RAC analyzes claims data using its proprietary software to perform targeted reviews intended to identify those claims most likely to contain overpayments.<sup>20</sup> Where overpayments are suspected, the Claim RAC sends to the provider a request for medical records. The provider has forty-five days to respond to this request by submitting copies of the medical records to the Claim RACs. For medical records requests, providers are permitted to request an extension prior to the forty-fifth day by contacting the Claim RAC.<sup>21</sup> The Claim RAC may be required to pay providers to offset the expense of producing records in accordance with current formulas under Medicare or any applicable payment formula created by state law (e.g., the current per page rate for Prospective Payment System providers<sup>22</sup>). The Claim RAC must complete its review and notify the provider of its decision within sixty days of receipt of the medical records requested. Where an overpayment is identified by the Claim RAC, a demand letter is sent to the provider and the provider essentially has two options: (1) submit the overpayment or agree with the RAC determination permitting an offset against future payments, as applicable or (2) submit a rebuttal letter to the Claim RAC identifying the basis for dispute, to which the Claim RAC must respond within 60 days.<sup>23</sup>



### C. **Overpayments and Underpayments**

Where a suspected overpayment is identified, the RAC does not adjust the claim; rather, it notifies the MAC that an overpayment has been identified via the RACs' database and the MAC adjusts the claim and reports the overpayment amount to the RAC.<sup>24</sup> The MAC is expected to perform necessary claim adjustments within fourteen calendar days of entry into the RAC database. The processing of a RAC determined overpayment will be the same as any other overpayment identified by a MAC.<sup>25</sup> Once the Claim RAC receives the overpayment amount from the claims adjustment by the MAC, it will proceed with recoupment.

Underpayments are handled in a similar fashion. The RAC sends a list of potential underpayments to the MAC, which in turn researches the potential underpayment, determines its legitimacy, and makes payment to the provider as necessary.<sup>26</sup> As with overpayments, administrative processing of RAC identified underpayments will not be any different than an underpayment determined by an MAC. Underpayments can be paid through an offset to overpayments made to the same healthcare

17 See CMS, Frequently Asked Question 7723.

18 *Id.*

19 See CMS, Frequently Asked Question 7724.

20 See CMS, Frequently Asked Question 6686.

21 See CMS, Frequently Asked Question 7723.

22 See 42 C.F.R. § 476.78(c).

23 Claim RACs follow the same process for issuance of demand letters as applicable to the MACs. For background information, see Medicare Financial Management Manual, Pub. 100-06, Chapter 3.

24 See generally Medicare Financial Management Manual, Pub. 100-06, Chapter 4, Section 100.

25 See generally Medicare Financial Management Manual, Pub. 100-06 Chapter 3.

26 See Medicare Financial Management Manual, Pub. 100-06, Chapter 4, Section 100.6.1.

provider.<sup>27</sup> In situations where an RAC identifies both overpayments and underpayments, the RAC will offset the underpayment from the overpayment. Where an underpayment is identified for which there is no overpayment to offset, RACs will inform the MAC, which will proceed with the claim adjustment and payment to the provider.<sup>28</sup>

Interest accrues from the date of the final determination of overpayment or underpayment. Interest is charged on the overpayment balance or paid on the underpayment balance for each full thirty day period that payment is delayed.<sup>29</sup> Any payments received from the provider are applied first to interest and then to the remaining principal balance.

#### D. **Demand Letters**

The RAC is required to follow the same practices for sending a demand letter as those applicable to MACs.<sup>30</sup> Demand letters instruct providers to send payment to the MAC. Payments received by the MAC are deposited and the MAC is required to update the RAC database within seven calendar days of applying the payment whether by check or offset. For delinquent payments, RACs are required to follow the normal referral to Treasury Process applicable to MAC initiated repayment requests. The RAC will issue the intent to refer to the United States Treasury, whether on or before one hundred thirty days of delinquency. After that, the case is transferred to the MAC, and the MAC proceeds with referral to the United States Treasury.

#### E. **Appeals**

Where the provider rebuts the overpayment and the RAC overturns that rebuttal, the provider then has the opportunity to appeal the claim with the MAC. All first level inpatient appeals are handled through the Fiscal Intermediary rather than the Quality Improvement Organization, as provided by the standard appeals process.<sup>31</sup> Otherwise, all non-inpatient services are handled through standard processes for MAC identified claims.<sup>32</sup>

Providers are to submit appeal requests to the MAC. Upon receiving an appeal, the MAC requests medical records from the Claim RAC through the Claim RAC database within seven calendar days of determining that a valid appeal has been made.<sup>33</sup> The Claim RAC then must forward or make available the medical records to the MAC within seven calendar days of notification through the Claim RAC database. Appeals are tracked in the Claim RAC database throughout the appeal process so that the Claim RAC can determine when recoupment proceedings must be stopped. The Claim RAC database includes status updates for every level of appeal, which must be updated by the MAC within seven calendar days of any change in status. Where an appeal decision is favorable to the provider, CMS is required to pay interest to the provider, as determined by CMS' interpretation of the appeal regulations.<sup>34</sup>

<sup>27</sup> See generally, MLN Matters No. SE0617.

<sup>28</sup> See FAQ 7727.

<sup>29</sup> See 42 C.F.R. § 405.378.

<sup>30</sup> See generally Medicare Financial Management Manual, Pub. 100-06, Chapter 4, Section 70

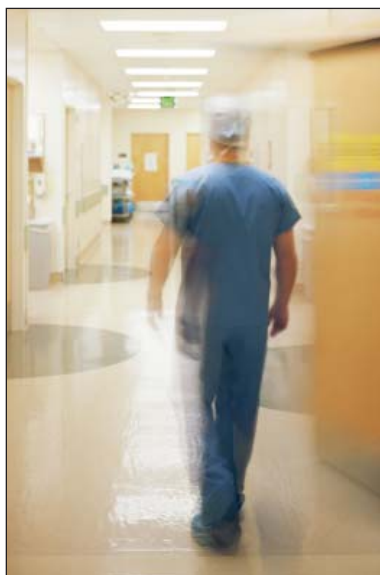
<sup>31</sup> See CMS, Frequently Asked Question 7736.

<sup>32</sup> See generally Medicare Claims Processing Manual, Pub. 100-4, Chapter 29.

<sup>33</sup> Medicare Financial Management Manual, Pub. 100-06, Chapter 4, Section 100.7.

<sup>34</sup> See FAQ 7730.

The demonstration project shows that providers have had a some success with appeals. In Fiscal Year 2007, 11.3% of RAC determinations were appealed.<sup>35</sup> Of those appealed, 44.2% of claims were decided in the provider's favor, but only 5% of overpayment collections were overturned.<sup>36</sup> A majority of the appeals filed have been challenges to the underlying medical necessity or coding determination made by the Claim RAC.



**IV. CMS Expansion Strategy.** To implement the nationwide Claim RAC program mandated by Section 302, CMS has developed four distinct RAC regions which match with the current DME MAC jurisdictions, each of which has been assigned to a Claim RAC selected through a competitive process.<sup>37</sup> The Claim RACs selected are as follows: Diversified Collection Services, Inc., Livermore, California – Region A; CGI Technologies and Solutions, Inc. of Fairfax, Virginia – Region B; Connolly Consulting Associates, Inc., Wilton, Connecticut – Region C; and HealthDataInsights, Inc., Las Vegas, Nevada – Region D. There is currently some uncertainty, however, as to whether the selection process is final. Two unsuccessful bidders – Viant and PRG-Schultz – have filed protests with the Government Accountability Office (GAO) pursuant to the Competition and Contracting Act of 1984. As a result of this protest, CMS is required to impose an automatic stay in the contract work of the Claim RACs. A decision by the GAO is expected in early February 2009 at which point it is anticipated that the selection process will be finalized and CMS' expansion strategy can continue.

The permanent Claim RACs will be substantially similar to the demonstration Claim RACs, with a few exceptions, all of which appear to be improvements from the perspective of providers. The permanent RACs would use standardized medical record request letters, would be required to have a medical director, would be required to have clinicians and coding experts, and would be required to pay back any contingency fee if the claim overturned on appeal, at any level.<sup>38</sup> In addition, CMS has established limits on the number of medical records that can be requested by Claim RACs per 45 day period.<sup>39</sup> For example, Claim RACs may not request from hospitals medical records for more than 10% of average monthly Medicare claims, up to a maximum of 200. This is expected to greatly reduce some of the hardship that has been placed upon providers in responding to medical record requests.

**V. The Demonstration Project Experience.** One clear benefit of the demonstration program for those providers located outside the demonstration project states is the opportunity to learn from the experiences of providers located within in the demonstration project states and to anticipate the types of claims that will be the subject of Claim RAC activity, at least in the initial stages of expansion.

**A. Amount of Improper Payments Identified in the Demonstration Project**

The CMS RAC Status Document for Fiscal Year 2007 (the most recent of such reports available) (the "Status Document") provides helpful insight into the nature and amount of improper overpayments that providers can expect will be identified.<sup>40</sup> Approximately 96% of all improper payments

35 CMS RAC Status Document, Fiscal Year 2006, Status on the Use of Recovery Audit Contractors in the Medicare Program, p. 20.

36 *Id.*

37 See CMS Expansion Strategy, available online at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp).

38 See Draft Statement of Work for the Recovery Audit Contractors, available online at [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac).

39 Available online at [http://www.cms.hhs.gov/RAC/03\\_RecentUpdates.asp#TopOfPage](http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage).

40 CMS RAC Status Document, Fiscal Year 2007, Status on the Use of Recovery Audit Contractors in the Medicare Program, page 11.

identified by Claim RACs were overpayments as compared to 4% for underpayments.<sup>41</sup>

The majority of overpayments collected by Claim RACs involved overpayment amounts of \$10,000-\$19,999 across all demonstration project states, with differentiation in overpayment amounts among provider types.<sup>42</sup> For example, in California, for Fiscal Year 2006, the average overpayment per provider for inpatient claims was \$75,856 compared to \$216 per physician/supplier.<sup>43</sup>

B. Types of Improper Payments Identified in the Demonstration Project

For Fiscal Year 2007, 88% of all overpayments identified were from inpatient hospital and skilled nursing facility providers, a vast majority of which were the result of overpayments to inpatient hospitals.<sup>44</sup> The next largest category by provider type was outpatient hospital (6%), followed by physician/supplier (3%), durable medical equipment (2%), and ambulance, lab, or other (1%). Interestingly, 99% of underpayments were from inpatient and outpatient hospitals and skilled nursing facilities. Physicians accounted for the remaining 1% of underpayments.<sup>45</sup>

The Status Document and other information releases on the findings of Claim RACs are an excellent source of information for this purpose and can serve as a useful tool for predicting what to expect when Claim RACs begin operations in other states as part of the expansion. For example, the Status Document identifies six inpatient hospital services that account for \$117.2 million in overpayments collected from inpatient hospitals in Fiscal Year 2007. In addition, the Status Document identifies service-specific examples of improper payments identified for inpatient hospital claims. Similar examples are available in previous Status Documents for non-inpatient hospital settings (*i.e.*, outpatient hospital, rehabilitation, and skilled nursing facility settings) and the physician setting. One approach available to providers is to focus efforts, at least initially, where large amounts of overpayments are identified among a small number of problem areas identified in the Status Documents.

**VI. Preparing and Planning for Claim RACs.** Providers should review and monitor CMS' expansion strategy to determine when to expect the arrival of a permanent Claim RAC. Given the impact that Claim RACs can have on provider cash flows and operations, no time is too soon to begin preparing for Claim RAC review of provider claims. One way for Providers to prepare is to proactively detect and correct any of its overpayments, identify its underpayments, and to implement actions that will prevent improper payments from occurring in the future.

In preparing for an expansion of a Claim RAC into its state, provider tactics could include:

1. Utilize available guidance from CMS and other sources, including Status Documents, Claim RAC websites, and the Department of Health and Human Services Office of Inspector General Work Plan to identify overpayment problem areas that are most likely to be pursued by Claim RACs and perform data mining and internal audits to detect any related overpayments.

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41 *Id.*

42 CMS RAC Status Document, Fiscal Year 2006, Status on the Use of Recovery Audit Contractors in the Medicare Program, page 11.

43 *Id.*

44 *Id.*, at 13.

45 *Id.*, at 13.

2. Establish techniques to better identify underpayments and process adjustments without relying upon Claim RAC activities.
3. Develop internal processes and operations to accommodate Claim RAC interaction, including identifying resources and key personnel appropriate for effective management of Claim RAC activities and establishing policies and procedures for processing demand letters, responding to medical records requests, and filing responses, rebuttals, and appeals.
4. Begin the process of educating practitioners and billing and coding staff on the findings of Claim RACs with the goal of preventing future improper payments.
5. Identify and correct weaknesses in existing medical records and supporting documentation practices and coding and billing policies and procedures and operations that could lead to improper payments.



**VII. Conclusion.** As Claim RACs expand nationwide, there will likely be a significant impact on providers, at least in the initial stages of operation within any given state. Use of available resources on Claim RACs and thoughtful planning and preparation could buffer the impact that Claim RACs can have on providers.