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CMS CONTINUES TO ROLL OUT RAC PROGRAMS, WITH SOME IMPROVEMENTS

After the success of the three-year Recovery Audit Contractor ("RAC") demonstration for Medicare Parts A and B, Congress authorized a permanent, nationwide program and later authorized similar programs for Medicare Parts C and D, and the State Medicaid programs. CMS has led the slow but steady rollout of these RAC programs, while making certain improvements that build on the changes to the permanent RAC program for Medicare Part A and Part B claims. Although these improvements may help to avoid procedural problems for health care providers, they are also designed to help overpayment determinations by RAC auditors withstand legal challenges on appeal. Yet, appealing such overpayment determinations remains the best way for providers to reclaim their right to Medicare reimbursement for services already provided.

Please feel free to reach us at the phone number or email address to the left if you have questions about these changes, or how to best prepare for and challenge adverse RAC determinations.

Medicare Parts A and B. Section 302 of the Tax Relief and Health Care Act of 2006 established the use of a permanent, nationwide group of RACs to identify underpayments and overpayments for Medicare Part A and Part B claims. The nation is divided into four RAC regions, each with a single RAC.¹ The RACs are unique in that they are paid contingency fees (currently between 9% and 12.5%) from the amount of overpayments recovered and the number of underpayments identified.

The RACs review claims on a post-payment basis, up to three years from the date the claim was paid. Most reviews fall into one of two categories – *automated reviews* based on a "black and white" determination that the service is not covered or is incorrectly coded, and *complex reviews* based on a more subjective review of the medical records for medical necessity, DRG validation, and coding errors. This year CMS approved a hybrid approach called *semi-automated review* that involves automated review of claims data to identify a billing aberrancy and a complex review of medical records to confirm the RAC's suspicion of an improper payment. The RACs are now performing all of these types of reviews. Issues that will be reviewed by RACs first must be approved by CMS. Each RAC posts issues approved for audit on its web site.

Medicare Parts C and D. Section 6411(b) of the Patient Protection and Affordable Care Act of 2010 (“Affordable Care Act”) expands the RAC program to Medicare Parts C and D. Rulemaking on this expansion has only progressed through an initial request for comment, issued late last year.² While section 6411(b) requires the Secretary to enter into contracts with RACs to conduct audits of Part C and Part D claims by December 31, 2010, no date is specified by which the audits must actually commence. CMS awarded a contract in January 2011 for a Part D RAC (ACLR Strategic Business Solutions) which was expected to start auditing in the third quarter of 2011. However, CMS noted in the request for comment that implementing RACs in the Medicare Advantage (Part C) program is more complicated because MA plans, not the government, are at risk for overpayments and underpayments.

Medicaid. Under section 6411(a) of the Affordable Care Act, each State must establish a Medicaid RAC program by way of a State plan amendment (“SPA”) prior to December 31, 2010. In a proposed rule issued by CMS on November 10, 2010, CMS required the States to implement their programs by April 15, 2011, allowing enough time for state legislatures that only meet for part of the year to convene and approve the SPA, if necessary.³ However, in a letter dated February 1, 2011, CMS informed the states that it would not require full operation of the Medicaid RAC programs by April 15, but would indicate a new start date in the final rule.⁴ CMS expects to publish a final rule before the end of this year.

Medicaid RACs will be paid on a contingency fee basis, in the same way as Medicare RACs, subject to a ceiling set at the highest fee for Medicare RACs (currently 12.5%) unless the state requests a waiver. Medicaid providers will be able to appeal overpayment determinations on Medicaid claims by using the state’s existing Medicaid audit appeal process, unless the state establishes a new appeal process to accommodate RAC appeals.

Recent RAC Improvements. The RAC program requires coordination between the RACs, Medicare Administrative Contractors (“MACs”), and Fiscal Intermediaries (“FIs”) after an erroneous payment is identified. In the past, the RAC was to send a letter to the provider notifying it of an overpayment or underpayment and communicate with the MAC or FI about that erroneous payment. The MAC/FI was then to send the provider a Remittance Advice (“RA”) that clearly identifies the claim for which an overpayment has been identified. A demand letter that explains the amount and timing of any recoupment, was to be sent separately.

In practice, this process has not always been followed, which has hampered the ability of providers to wage a timely and effective appeal, particularly when the provider seeks to stay recoupment during the appeal. A provider needs to receive clear notice of an overpayment determination, indicating the reasons for the denial, and the claim to which it applies to understand the timing of recoupment and how much time it has to appeal. However, all too often, demand letters were not sent or RAs failed to clearly convey this information.

Because of inconsistent RA practices used by the RACs, MACs and FIs, CMS issued Change Request 6870 (June 9, 2011) to establish better standards. MACs/FIs now have to use specific codes in the Provider Level Adjustment (confusingly abbreviated PLB) section at the Provider Level of the RA. The first RA issued will show at the claim level that the original payment has been replaced by a new payment. At the provider level, the RA will contain reason code "FB" in PLB 03-1, which is the code for "Forward Balance." PLB 04 indicates the adjustment amount needed to offset the claim level net adjustment amount, so that the Remittance Advice balances out to zero. This accounting step is necessary because the first RA creates an account receivable, but recoupment has not yet occurred. Thus, the actual payment impact of the first RA is zero. A demand letter is also issued to the provider containing the same control number as the RA.

When recoupment actually occurs, the MAC/FI issues a second RA identical to the first except with reason code "WO" in PLB 03-1, which is the code for "overpayment recovery". At this stage, PLB 04 displays the actual amount being recouped.

These changes, which were fully implemented on July 5, 2011, should significantly reduce the confusion caused by the inconsistent notice practices of the RACs, MACs and FIs under the RAC program to date. With the information presented more clearly, providers should be able to more easily monitor the deadlines for requesting an initial appeal (redetermination) of an adverse RAC decision. Although a provider has 120 days from the date of the demand letter to appeal, in order to stay recoupment of the overpayment the provider must file a complete request for redetermination within *30 days* after the date of the demand letter. The MAC/FI can recoup the overpayment in full if a valid request for redetermination has not been received by the 41st day after the demand letter date (see Change Request 6183 (September 12, 2008)).

Because the provider's receipt of a demand letter starts the clock to appeal and stay recoupment, it is crucial that the provider receive the demand letter in a timely fashion. Per Change Request 7436 (July 29, 2011), CMS has shifted the responsibility for sending demand letters from the RAC auditors to the MACs and FIs. Consolidating the RA and demand letter functions within a single entity should increase coordination and make the issuance of demand letters more reliable.

Appeal Statistics. According to CMS's June 2010 final report on the RAC three-year demonstration program that preceded the nationwide rollout of A/B RACs, only 12.7% (76,073 of 598,238) of RAC determinations were appealed.⁵ Of these appealed claims, 64.4% were decided in the provider's favor. A more recent survey conducted by the American Hospital Association ("AHA") that tracks RAC activity through the first quarter of 2011 found even better results – providers appealed about one quarter of RAC denials and 71% of those denials were overturned on appeal.⁶ The AHA surveyed general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals),

long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

These statistics show that Medicare providers continue to have strong odds of getting an overpayment reversed by waging a timely appeal. With the recent improvements CMS put in place for proper notification of RAC audit overpayments through RAs and demand letters, providers should be in a better position to initiate early appeals to stay recoupment. Providers can also monitor RAC web sites for new issues approved by CMS for auditing. Developing these practices now will help as RAC audits expand into Medicare Parts C and D and Medicaid claims.

1. Region A (Northeast) is audited by Diversified Collection Services; Region B (Great Lakes) is audited by CGI Technologies and Solutions; Region C (Southeast) is audited by Connolly Consulting Associates; and Region D (Plains and West) is audited by HealthDataInsights.
2. Medicare Program: Solicitation of Comments Regarding Development of a Recovery Audit Contractor Program for the Medicare Part C and D Programs, 75 Fed. Reg. 81,278 (Dec. 27, 2010).
3. Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69,037 (Nov. 10, 2010).
4. CPI-CMCS Informational Bulletin CPI-B 11-03, Clarification of CMS expectations for State implementation of Medicaid Recovery Audit Contractor (RAC) programs, CMS (Feb. 1, 2011).
5. The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, CMS (June 14, 2010), *available at*: <http://www.cms.gov/Recovery-Audit-Program/Downloads/DemoAppealsUpdate61410.pdf>.
6. Exploring the Impact of the RAC Program on Hospitals Nationwide: Results of AHA RacTrac Survey, 1st Quarter 2011, AHA (May 20, 2011) *available at*: <http://www.aha.org/aha/content/2011/pdf/52011-1st-qtr-2011-RACTrac-report.pdf>.

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