

# Recovery Audit Contractors (RACs) and RUGs Audits



The Good, the Bad, and the Inevitable

Presented by:

Carla Cox, Jackson Walker LLP





# All About RACs

---

- What is a RAC?
- Will the RACs affect me?
- Why RACs?
- What does a RAC do?
- What are the providers' options?
- What can providers do to get ready?



# What is a RAC?

## The RAC Program Mission

---

- The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments
  - **Providers** can avoid submitting claims that do not comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** and future Medicare beneficiaries are protected

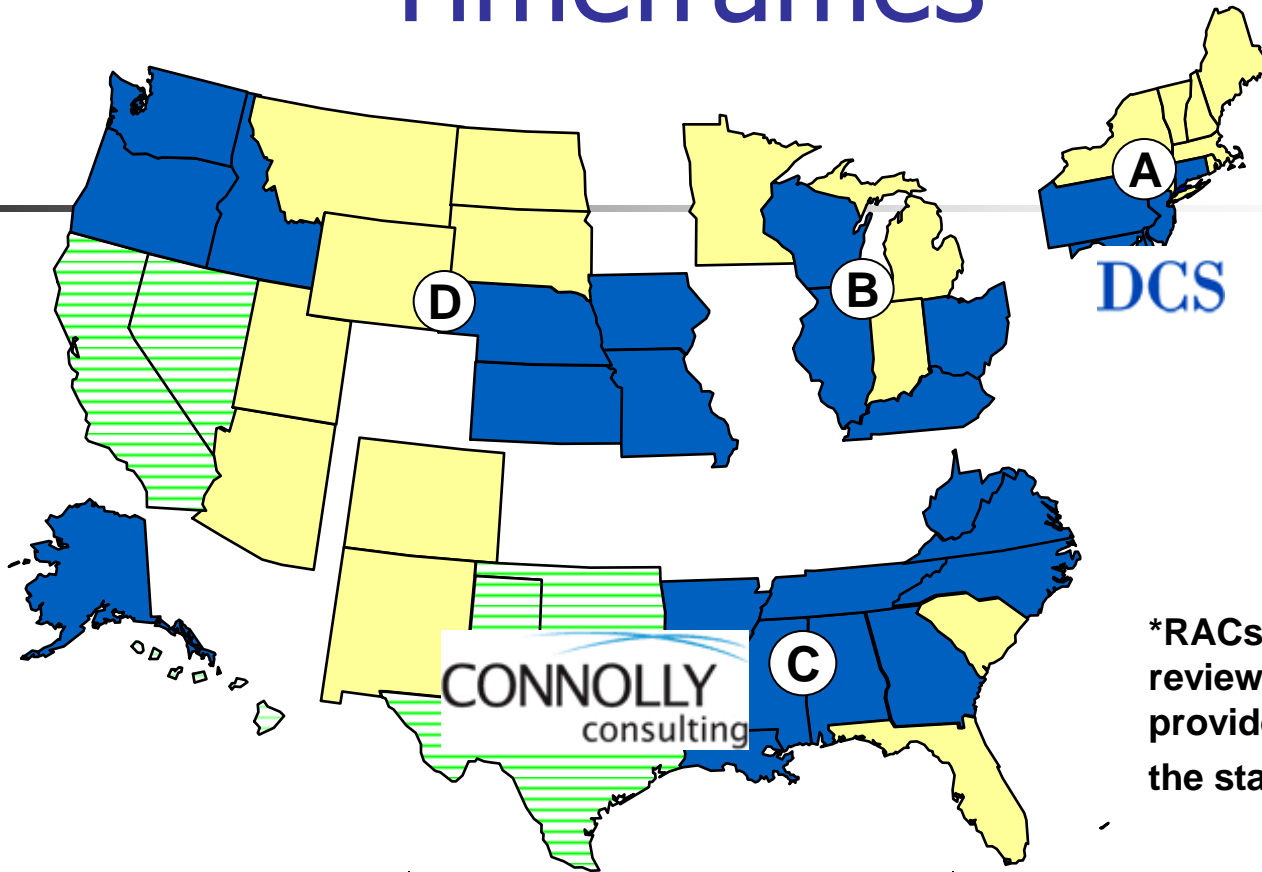


# Will the RACs affect me?

---

- Yes, if you bill fee-for-service Medicare programs, your claims will be subject to review by the RACs
- If so, when?

# Timeframes

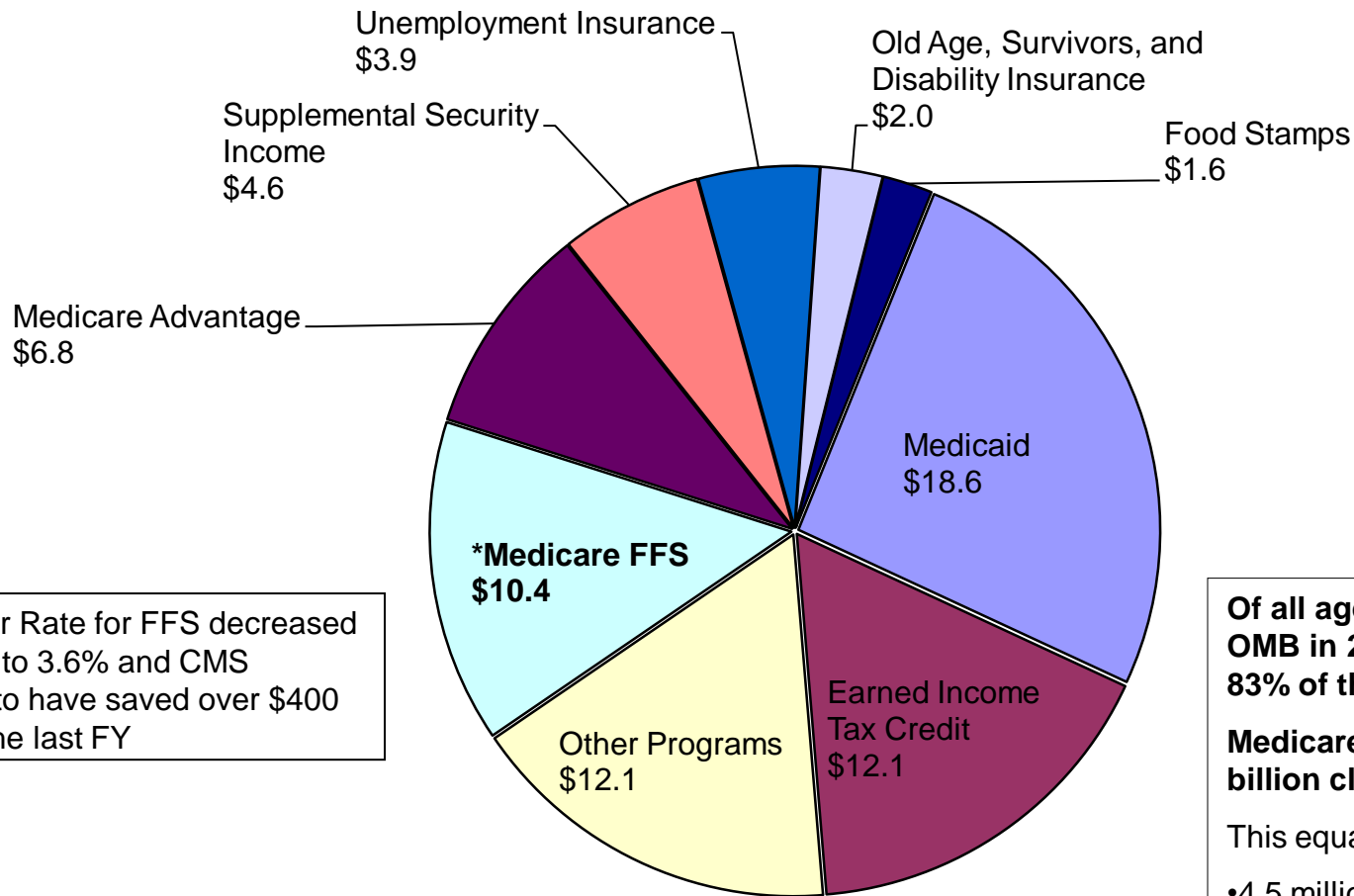


\*RACs may not begin reviewing until there is provider outreach in the state

Claims Available for Analysis	Provider Outreach	Earliest Correspondence
March 1, 2009	March 1, 2009	March 1, 2009
March 1, 2009	March 1, 2009	March 1, 2009
August 1, 2009	August 1, 2009	August 1, 2009

# Why do we have RACs?

## Top Federal Programs with Improper Payments 2008 (Billion Dollars)



\*2008 Error Rate for FFS decreased from 3.9% to 3.6% and CMS estimates to have saved over \$400 million in the last FY

Of all agencies that reported to OMB in 2008, these 8 make up 83% of the improper payments.

Medicare receives over 1.2 billion claims per year.

This equates to:

•4.5 million claims per work day



# What does a RAC do?

## RAC Review Process

---

- RACs review claims on a post-payment basis
- RACs use the same Medicare policies as Carriers, FIs and MACs
- Two types of review:
  - Automated (no medical record needed)
  - Complex (medical record required)
- RACs will be able to look back three years from the date the claim was paid
- RACs are required to employ a staff consisting of nurses or therapists, certified coders, and a physician medical director



# The Collection Process

---

- Demand letter is issued by the RAC
- RAC will offer an opportunity for the provider to discuss the improper payment determination with the RAC (this is outside the normal appeal process)
- Issues reviewed by the RAC will be approved by CMS prior to widespread review
- Approved issues will be posted to a RAC website before widespread review





# Provider Burden Limited by Guidelines Developed in Pilots

- RAC “look back period” to three years
  - Maximum look back date is October 1, 2007
- RACs will accept imaged medical records on CD/DVD
- Limit the number of medical record requests
- But must adhere to the provider medical record submission requirements

# New Issue Review Process for **AUTOMATED**

RAC sends  
New Issue  
Review  
Request  
to CMS

CMS  
reviews  
and  
decides

If approved,  
Issue is posted to  
RAC website and  
RAC may begin  
widespread review

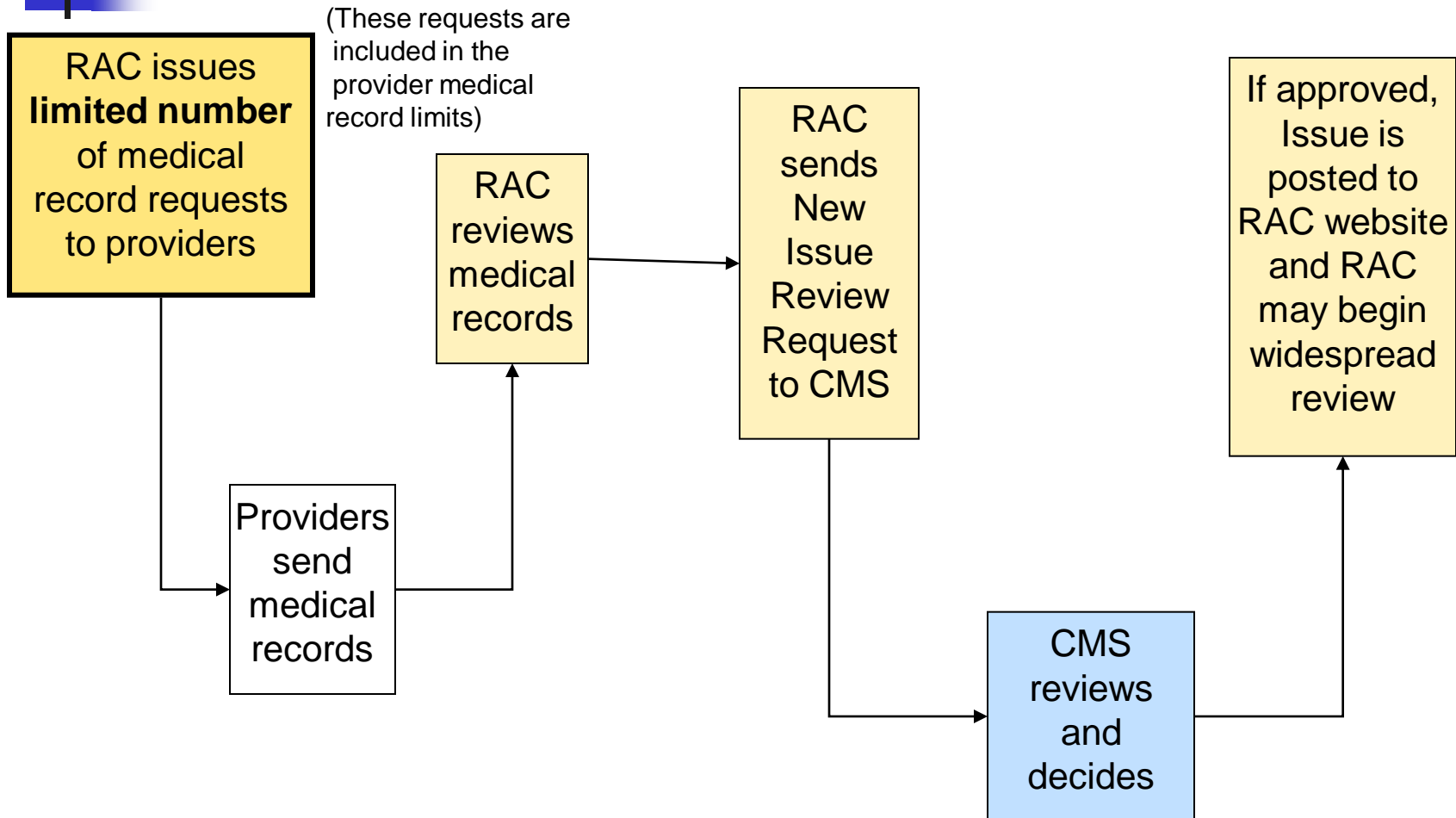
NOTE: **All**  
demand letters  
are sent AFTER  
CMS has  
approved the  
New Issue for  
Review

# Approved Issues for Automated Audit



- Connolly website for CMS approved issues for automated audits:  
[http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)
- The list indicates which provider types will be affected by the listed audits
- The good news—none of the issues to date affect SNF providers

# New Issue Review Process for **COMPLEX**



# What can providers do to get ready?



- Know where previous improper payments have been found
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC medical record requests



# Know Where Previous Improper Payments Have Been Found



- Look to see what improper payments were found by the RACs:
  - Demonstration findings: [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
  - Permanent RAC findings: will be listed on the RACs' websites
- Look to see what improper payments have been found in OIG and CERT reports
  - OIG reports: [www.oig.hhs.gov/reports.html](http://www.oig.hhs.gov/reports.html)
  - CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)

# Prepare to Respond to RAC Medical Record Requests




- Tell your RAC the precise address and contact person they should use when sending Medical Record Request Letters
- **DUE DATE: 45 days from the date of the medical record request letter**
- Description of format for medical records  
[http://www.connollyhealthcare.com/RAC/pages/record\\_submission.aspx](http://www.connollyhealthcare.com/RAC/pages/record_submission.aspx)

Who will be in charge of responding to RAC Medical Record requests?

What address will we use?

Who will be in charge of tracking our RAC Medical Record requests?

# Complete, submit, and keep current your Request for Contact Information form

  
**CONNOLLY**  
healthcare  
**Request for Contact Information**

Connolly Consulting is the Region C Recovery Auditing Contractor for the CMS RAC Program. Connolly is requesting a contact person for the potential recovery of underpayment/overpayment of claims, and a contact person for medical record request. After completing the below information, please fax to the attention of Christine Castelli, Principal of Connolly Consulting Associates, at the following fax number (203) 529.2995. **If you represent multiple facilities/providers, please complete a form for each facility/provider.**

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_  
Group Name: \_\_\_\_\_ Medicare Group Number: \_\_\_\_\_  
Tax Identification Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ NPI #: \_\_\_\_\_

---

**Contact for Potential Recovery of Underpaid/Overpaid Claims**

Contact Person: \_\_\_\_\_  
Title: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Contact's Telephone Number: \_\_\_\_\_  
Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**CHECK HERE IF YOU WANT ALL CORRESPONDENCE, INCLUDING MEDICAL RECORDS REQUESTS, TO BE DIRECTED TO THE ABOVE INDIVIDUAL. OTHERWISE, COMPLETE THE NEXT SECTION.**

**Contact for Medical Record Request**

Contact Person: \_\_\_\_\_  
Title: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Contact's Telephone Number: \_\_\_\_\_  
Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*If your contact person(s) changes, please update this form and resubmit to Connolly for processing.**

One Crescent Drive, Suite 300, Navy Yard Corp. Ctr., Philadelphia, PA 19112  
(p) 866.360.2506 – (f) 203.529.2995  
web Connolly-consulting.com





# What are Providers' Options

---

- Pay by check
- Allow recoupment from future payments
- Request or apply for extended repayment plan
- Appeal
  - The Appeal Process Brochure:

<http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>



# Appeal When Necessary

- The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC denials
- Do not confuse the “RAC Discussion Period” with the Appeals process
  - If you disagree with the RAC determination...
    - You may send a rebuttal letter within 15 days of receipt of demand letter
    - Do not stop with sending a rebuttal letter

Who will be in charge of deciding whether to appeal a RAC denial?

How will we keep track of what we want to appeal, what we have appealed, what our overturn rate is, etc.?

# Results of Appeals



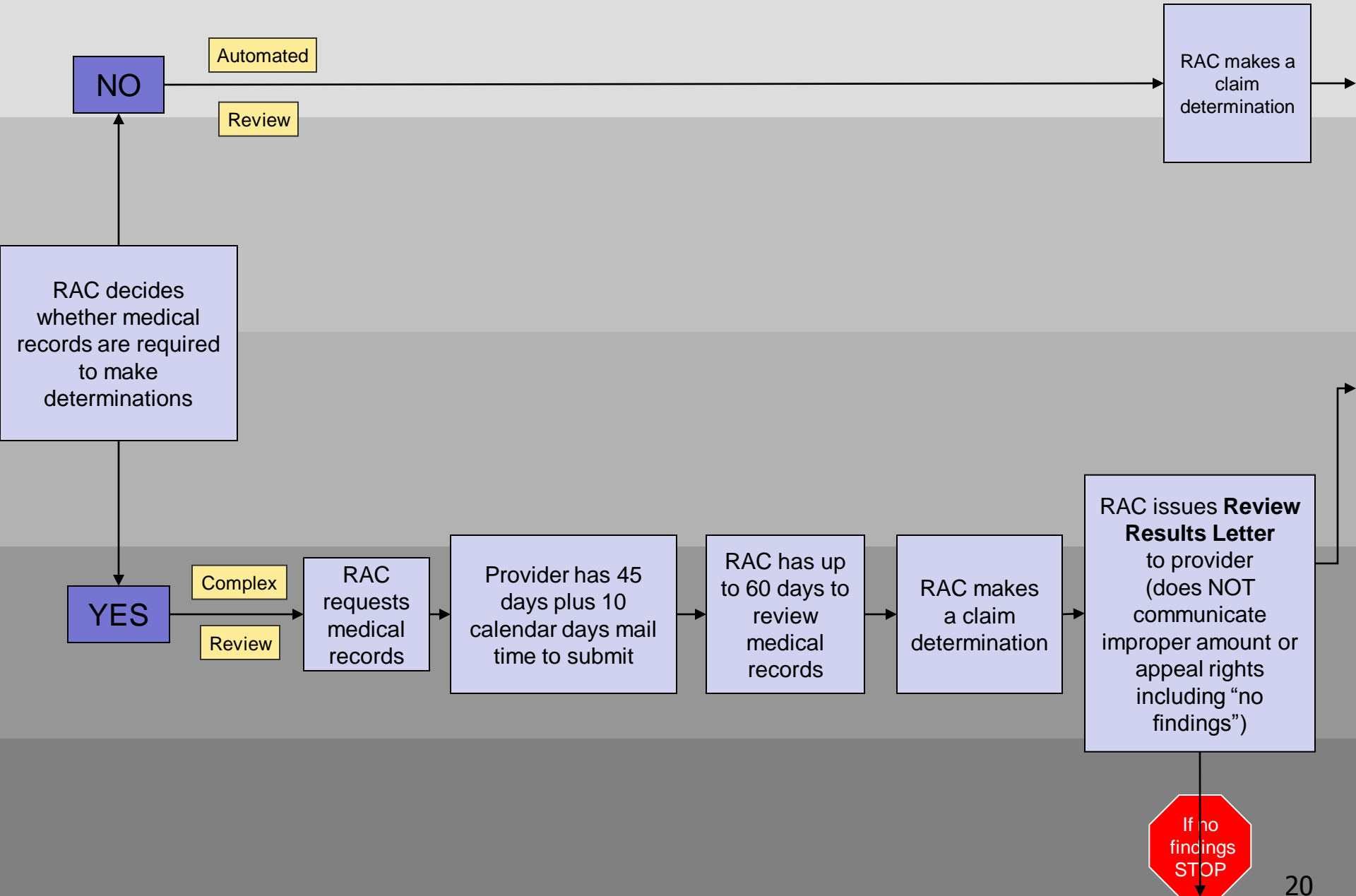
## Appendix 1a

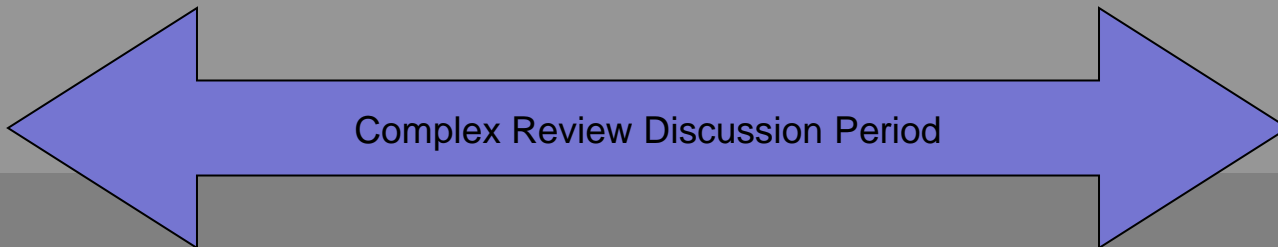
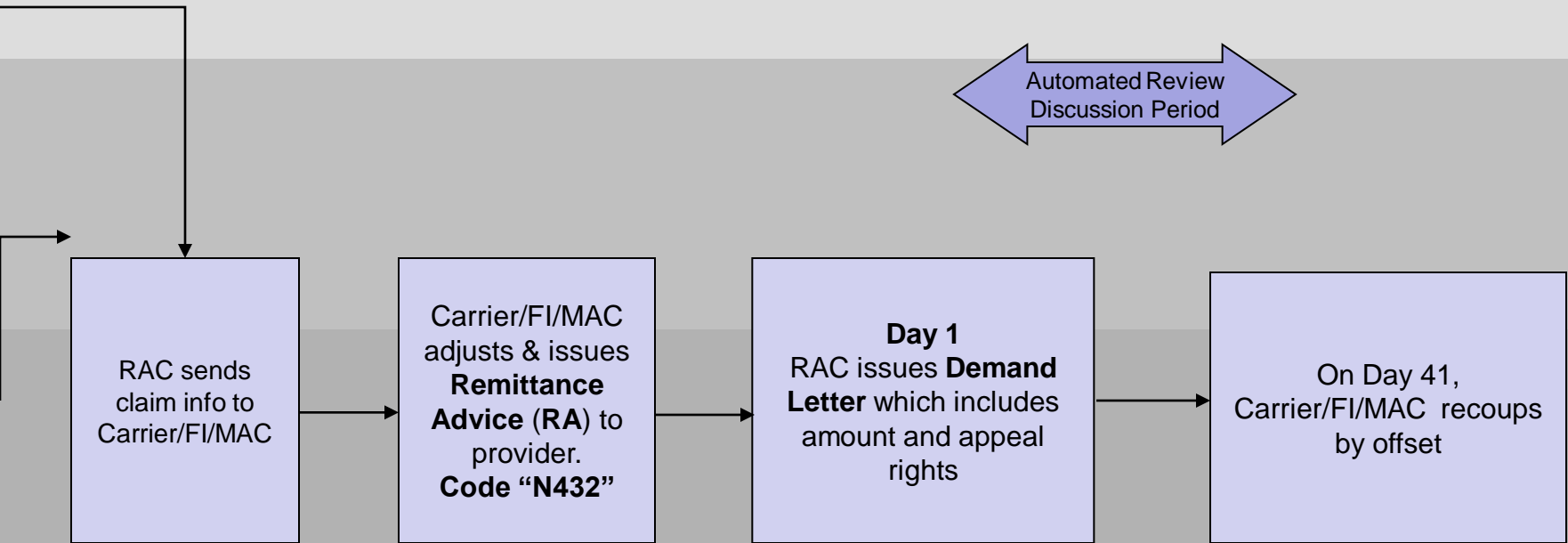
### Provider Appeals of RAC-Initiated Overpayments: Cumulative through 8/31/08, RAC Claims, All Claim Types

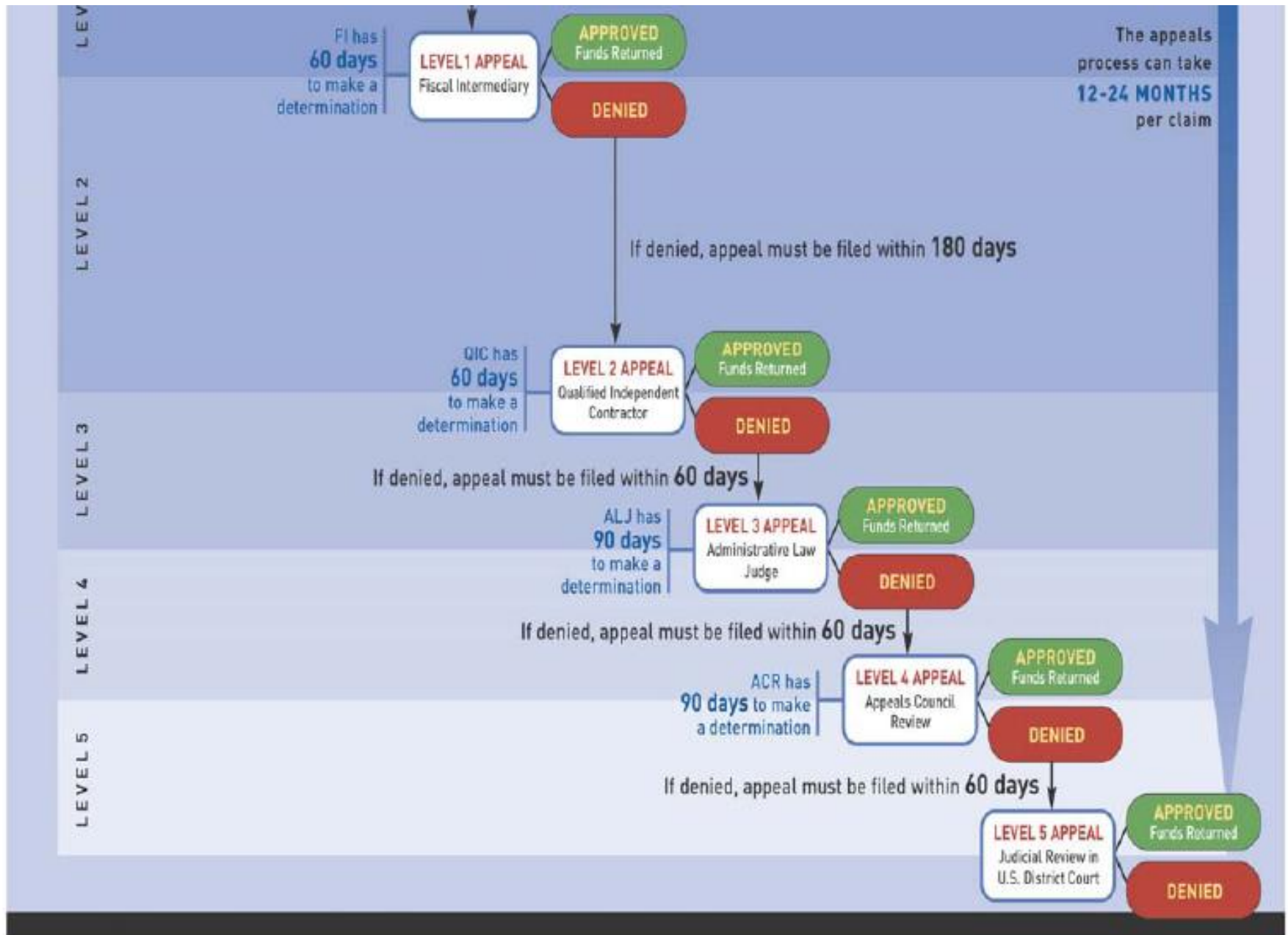
Claim RAC	Claims with Overpayment Determinations	# appealed (all levels)	% appealed (all levels)	# favorable to provider	% favorable to provider	% of all claims overturned on appeal
Connolly	118,152	8,286	7.0%	5,543	66.9%	4.7%
HDI	309,080	44,778	14.5%	32,628	72.9%	10.6%
PRG	171,006	14,965	8.8%	7,448	49.8%	4.4%
RAC not known <sup>1</sup>	n/a	8,044	n/a	3,374	41.9%	n/a
All RACs	598,238	76,073	12.7%	48,993	64.4%	8.2%

Source: RAC invoice files, RAC Data Warehouse, and data reported by the AdQIC and Medicare claims processing contractors. Includes all completed appeals and some pending appeals. This is because some Medicare claims processing contractors cannot distinguish between pending appeals of RAC determinations and pending appeals of other contractor determinations. These statistics are based on appeals that were known to the AdQIC and Medicare claims processing contractors on or before 3/9/10. Any QIC or ALJ appeals processed by the appeal entities or reported to the Medicare claims processing contractors after that date are not included in these statistics.

# RAC Process







# Timetable for Avoiding Recoupment



**200.2.2- Recoupment After the First Demand: When Does it Begin?**  
 (Rev.141, Issued: 09-12-08, Effective: 09-29-08, Implementation: 09-29-08)

<i>Timeframe</i>	<i>Medicare Contractor</i>	<i>Provider</i>
<i>Day 1</i>	<i>Date of Demand Letter (Date demand letter mailed)</i>	<i>Provider receives notification by first class mail of overpayment determination</i>
<i>Day 1-15</i>	<i>Day 15 deadline for Rebuttal request. No recoupment occurs</i>	<i>Provider must submit a statement within 15 days from the date of demand letter.</i>
<i>Day 1-40</i>	<i>No recoupment occurs</i>	<i>Provider can appeal and potentially limit recoupment from occurring</i>
<i>Day 41</i>	<i>Recoupment begins</i>	<i>Provider can appeal and potentially stop recoupment</i>

# How to Stop Recoupment From First Demand



- Recoupment can proceed on day 41 from first demand letter unless
- Provider files a request for redetermination by **30<sup>th</sup>** day following date of first demand letter
- Recoupment cannot begin earlier than 41<sup>st</sup> day



# How to Stop Recoupment From Second Demand



- Recoupment can proceed on day 61 from first demand letter unless
- Provider files valid appeal of the unfavorable or partially favorable decision by **60<sup>th</sup>** day following date of second demand letter
- Recoupment cannot begin earlier than 61<sup>st</sup> day

# Understanding Limitation on Recoupment



- Limitation on recoupment applies to 1<sup>st</sup> and 2<sup>nd</sup> levels of appeal ONLY
- Medicare will not begin recoupment of overpayment (or will cease recoupment that has started) when it receives notices that the provider has requested a redetermination (first level appeal) or a reconsideration (second level appeal to QIC)
- After QIC decision unfavorable to provider, Medicare will recoup any outstanding overpayment

# Voluntary Repayments= No Interest



- A provider can pay an "overpayment" back as a lump sum or through an extended repayment plan ("ERP") to avoid the accrual of interest
- Can still pursue an appeal
- Voluntary payment can be made at any point during the appeals process
- If the payment is made after the initial 30 days have passed since notice of the overpayment, the provider will have to pay the overpayment amount plus any interest due up to the point of appeal
- No additional interest will accrue thereafter

# How Appeal Results Impact Recoupment and Interest



- Appeal successful—overpayment and interest recouped will be refunded. Medicare pays interest on the principle recouped but not on any interest (e.g., it pays simple and not compound interest) and follows these rules:
- If money is recouped by Medicare and the provider then wins an appeal at the ALJ level or higher, Medicare must refund the recouped amount plus interest on the principal recouped (calculated at 30-day intervals) from the date of recoupment.
- If the provider wins on appeal at the earlier redetermination or reconsideration stages, Medicare must refund any recouped amount but must only pay interest on the principal recouped if the recouped amount is not returned within 30 days of the date of final redetermination.
- See 74 Fed. Reg. 47458 (Sept. 16, 2009); 42 CFR 405.378.

# Repayments and Interest



- **IMPORTANT:** Medicare does not treat voluntary payments made as a lump sum or through an ERP as "recoupments"
- The rule requiring Medicare to pay interest to a provider (discussed in the first bullet point above) specifically applies to "funds that have been recouped and retained by the Medicare contractor." See 42 CFR 405.378(j)
- Thus, if Medicare must return voluntary payments (either paid in lump sum or through a payment plan), it is not subject to the interest rules that apply for a reversal at the ALJ level or higher
- Interest is paid on voluntarily paid principle only if it is not returned within 30 days of the date of final redetermination

# Learn from Your Past Experiences



- Keep track of denied claims
- Look for patterns
- Determine what corrective actions you need to take to avoid improper payments

Who will be in charge of tracking our RAC denials, looking for patterns?

How will we avoid making similar improper payment claims in the future?



# Contacts

---

- RAC Website: [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)
- RAC Email: [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

# Connolly Resources

- Connolly RAC toll free phone number
  - 866.360.2507
- Connolly RAC fax number
  - 203.529.2995
- Connolly website & email address
  - [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC)
  - [RACinfo@connollyhealthcare.com](mailto:RACinfo@connollyhealthcare.com)
- Connolly RAC office address
  - The Navy Yard Corporate Center
  - One Crescent Drive, Suite 300-A
  - Philadelphia, PA 19112
- Christine Castelli
  - 203.529.2315





# Medicaid RACS

- States must submit State Plan Amendments by 12/31/10 to establish Medicaid RAC programs by 4/01/11
- States may not substitute RACs for existing State Medicaid program integrity audit programs—must maintain existing state audit programs at existing funding and activity levels
- Medicaid RACs will work on contingency basis of funds recovered up to a maximum to be set by CMS (highest current Medicare RAC contingency is 12.5%)



## Medicaid RACS (cont.)

- RACs' contingency fees will “come off the top” of funds recovered before calculation of federal match to be repaid by state to CMS
- RACs will identify underpayments to providers as well as overpayments
- Medicare RAC ratio of identified overpayments to underpayments=9 to 1



## Medicaid RACS (cont.)

- States must have adequate program for appeal Medicaid RAC decisions
- May use same process as existing administrative appeal process for appeals of Medicaid audits
- Currently not clear what appeal process will be or how recoupments will be handled during appeal process



# RUGS Audits

- RUGS audits will replace TILE audits
- Reviews will be conducted by HHSC-OIG Utilization Review
- Reviews will examine records retrospectively to October 9, 2008
- Reviews to begin October or November 2010



# RUGS UR Procedure

- Utilization Review Rules: 1 TAC §371.214(n)
  - Onsite review basically same as TILE reviews
  - Nursing facility must provide documentation to validate items claimed on MDS
  - Lack of documentation=error and RUG group reclassification

# Extrapolation of RUGS Errors



- RUGS errors extrapolated to total NF population to calculate overpayment
- Extrapolation to be phased in for rates over 25%, 20% down to 15%
- Phase-in dates for extrapolation of error rates have passed due to delay in initiation of review process

# Waiver of Extrapolation of RUGS Errors



- Rather than proposing new phase-in periods, HHSC has proposed new rule for waiver of extrapolation of error rates
- Proposed rule 1 TAC §371.216 requires provider to request waiver of extrapolation ***in writing on or before 15<sup>th</sup> calendar day*** after receipt of final notice of overpayment
- Request for waiver must show good cause
- OIG has ***sole discretion*** to grant waiver and decision is not subject to administrative or judicial review

# Reconsideration Review of RUGS Error Rates



- Provider may request reconsideration of error rate from on site review ***in writing on or before 15<sup>th</sup> calendar day*** after date of exit conference
- If no request for reconsideration is filed, on-site error rate will be used to calculate overpayment



# Appeal of RUGS Error Rates



- Provider may appeal adverse reconsideration decision ***in writing on or before 15<sup>th</sup> calendar day*** after receipt of notice of decision
- Appeal will not halt recovery of overpayment
- When OIG began TILE audits, error rates soared
- Providers should appeal to curtail OIG overstatement of error rates due to questionable on-site findings