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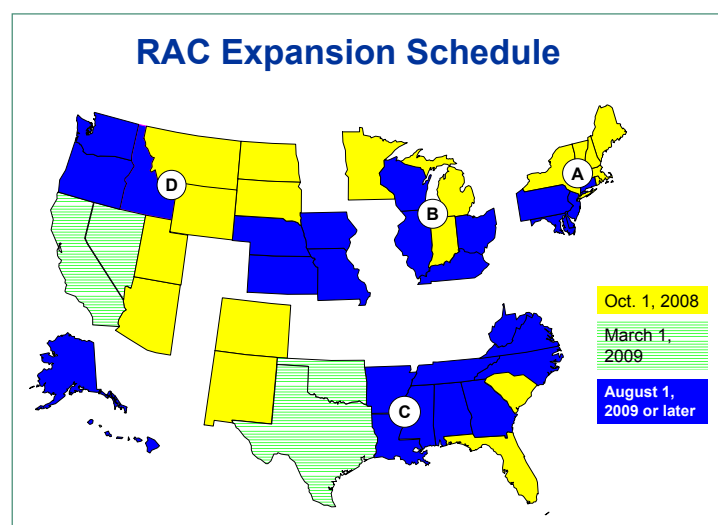
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Recovery Audit Contractor Program Resumes in February 2009: What Every Medicare Provider and Supplier Should Know About RAC Audits and Appeals

By now, most Medicare providers have heard about the Medicare Recovery Audit Contractor ("RAC") demonstration and that it is currently being rolled out nationwide as a permanent program. The problems that arose during the three-year demonstration may sound familiar, such as the RAC audits of inpatient rehabilitation facility ("IRF") claims in California that the Centers for Medicare and Medicaid Services ("CMS") eventually halted when it was discovered that the RAC was not consistently following Medicare rules and policies. But because the demonstration program that ended in March of last year was limited to six states (New York, Florida, California, Massachusetts, South Carolina, and Arizona), it may not be obvious to all providers and suppliers that RACs pose a threat. To understand that threat and how best to address it, it is important to understand where RACs will operate; what RAC auditors are designed to do and how they audit; where your claims fit within a RAC's set of priorities; and your rights as a Medicare provider or supplier to challenge RAC overpayment determinations.

Where Will RACs Operate?

Congress authorized the RAC demonstration in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173. Section 302 of the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, made the RAC program permanent and called for expanding the program to all 50 states no later than 2010. There are four separate regions of the country under the permanent program. CMS plans to have one RAC in each region. On October 6, 2008, CMS announced the four RACs: Diversified Collection Services (Region A); CGI Technologies and Solutions (Region B); Connolly Consulting Associates (Region C); and HealthDataInsights (Region D). The last two were RACs under the demonstration program. Below is the expansion schedule CMS published on its website that provides the estimated dates for the roll-out in each region.



On November 4, 2008, however, CMS imposed an automatic stay on the RAC program after two unsuccessful bidders for RAC contracts filed protests with the Government Accountability Office ("GAO"). Viant Inc. and PRG-Schultz International, both auditing contractors during the RAC demonstration, were not awarded one of the four permanent RAC contracts. GAO has 100 days to issue its decision, which means that all RAC program work is on hold until early February 2009.

What Are RACs and How Do They Audit?

RACs are private entities with at least three years of direct management and health insurance auditing experience. Medicare fiscal intermediaries ("FIs"), carriers, and Medicare Audit Contractors (MACs) are ineligible. RACs audit Medicare Part A and Part B claims for overpayments and

underpayments. They analyze claims data using proprietary techniques to identify claims that contain clear errors using what is known as automated review, as well as claims that likely contain errors using what is known as complex review based on a further review of medical records requested from the provider. RACs follow the same Medicare rules and policies to identify overpayments as Medicare claims processing contractors. Each RAC has a medical director and must use medical personnel such as nurses, therapists, and certified coders to review claims. The look-back period is three years at most and cannot include claims paid before October 1, 2007. Certain claims are excluded from a RAC's review, such as claims previously reviewed by another Medicare contractor.

Unlike any other Medicare contractor, RACs are paid a contingency fee based on the amount of improper payments they correct for both overpayments and underpayments. The contingency fee is negotiated with CMS and varies by RAC. Contingency fees for the permanent RACs range from 9 percent to 12.5 percent. A contingency fee incentivizes RACs to find incorrect payments. For this reason, RACs are often compared to bounty hunters because they don't get paid unless they find an overpayment or underpayment. During the demonstration, the improper payments RACs discovered were almost exclusively overpayments. In a September 2008 report, CMS stated that RACs succeeded in correcting more than \$1 billion of improper Medicare payments during the demonstration: \$992.7 million in overpayments, and \$37.8 million in underpayments. Of all claims identified as overpayments during the demonstration, approximately 42 percent were incorrectly coded, 32 percent were for medically unnecessary service or setting, 9 percent lacked some or all supporting documentation, and 17 percent were for other errors.

Where Do Your Claims Fit Within RAC Priorities?

A contingency fee provides RACs with a strong incentive to be efficient and focus on large dollar claims which give the highest return for the expense of reviewing the claim. Not surprisingly, RACs focused their efforts during the demonstration on inpatient hospital claims. Approximately 85 percent of overpayments identified by RACs during the demonstration were collected from inpatient hospitals. To a lesser extent, RACs also audited Medicare claims for outpatient hospital services, skilled nursing facilities, long-term acute care hospitals, IRFs, physicians, ambulance, clinical laboratories, and DME suppliers. As the permanent RAC program is expanded to more states, RAC audits will be more prevalent.

What Rights Do Medicare Providers and Suppliers Have to Challenge RAC Overpayment Determinations?

All providers and suppliers have the right to appeal RAC overpayment determinations through the appeal process for Medicare claims. This is a multi-level appeal process with firm deadlines. It begins with a redetermination by the FI, followed by a reconsideration by a qualified independent contractor ("QIC"), proceeds to a hearing before an administrative law judge ("ALJ"), can be reviewed by the Medicare Appeals Council ("MAC"), and ends in federal court, if necessary. New rules allow appellants to obtain a stay on the recoupment of an alleged overpayment during the first and second levels of appeal if appeals are filed quickly.

CMS has published data on appeal results through June 30, 2008 that show providers have appealed one out of every five claims the demonstration RACs determined to be an overpayment. Approximately 35 percent of appealed claims were reversed in part, and approximately 7 percent were reversed in full, in favor of the provider. However, only about 5 percent of appealed claims were appealed beyond the first level of appeal, an FI redetermination. In our experience, a truly independent and considered review of the claim does not come until the appeal reaches an ALJ. Therefore, the number of appeals that were fully favorable to providers during the demonstration period would likely have increased if more cases were appealed higher than the FI redetermination level.

Based on this data and the fact that RACs now must repay contingency fees for overpayments reversed at any level of appeal, providers and suppliers that respond to RAC overpayment determinations with a well-coordinated appeal effort using experienced appeal representatives have a good chance of getting the overpayment determination reversed and may actually help deter additional RAC audits of similar claims in the future. An appropriate use of legal defenses and, in some cases, expert witnesses can enhance the odds of a successful appeal.

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The Life Sciences and Health Industry Group at Reed Smith has considerable experience and success representing both providers and suppliers in Medicare reimbursement appeals. If your

Medicare claims are subject to a RAC audit or other type of Medicare review, we can assist you with every aspect of the review and appeal, as well as obtaining a stay on recoupment during the initial stages of appeal, and RAC planning and compliance measures. For more information, please contact the author of this Alert.

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