# Medicare's Recovery Audit Contractor Program Expands Reach

The Tax Relief and Health Care Act of 2006 ("TRHCA") requires the expansion of the Medicare Recovery Audit Contractor ("RAC") program, under which contingent fee compensated RACs conduct audits to identify Medicare overpayments and underpayments, to all 50 states by 2010. With the receipt of claims data in two new states and the ongoing receipt of such data in three other states, that expansion is well underway. Providers who have not yet experienced a RAC audit should prepare by identifying high-risk and high-volume services and establishing a uniform process for responding to RAC audits.

## Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized the RAC program on a three-year demonstration basis in three states: New York, California and Florida. The TRHCA made the RAC program permanent.

RACs have two primary tasks: (1) detecting and (2) correcting improper Medicare payments (overpayments and underpayments). RAC review is not intended to replace any other review efforts by Medicare or its contractors; rather, it creates another level of review. RACs receive claims data directly from a Medicare provider or supplier's fiscal intermediary ("FI") or carrier on a quarterly basis and are authorized to look back four years from the date a claim was paid. RACs are required to review the appropriateness of each claim by applying the same standards and guidance (such as Medicare regulations, manuals, and local and national coverage determinations) as were used by the Medicare contractor at the time a claim was submitted. RACs engage in both automated and complex claims review. The latter review requires a provider to supply a paper copy of the medical record in support of the claim at the RAC's expense. A provider's failure to submit a requested medical record to a RAC within 45 days, absent good cause for delay, results in disallowance of a claim and demand for recoupment of any reimbursement paid.

## Appeals process

The appeals process for RAC audits is similar to the existing appeals process for individual claims, with two differences. First, providers are given 15 days from the date they receive an improper payment letter from a RAC to rebut the RAC's findings, although providers are not required to go through this rebuttal process before filing an appeal. Second, a provider appealing a RAC determination must file an appeal to its FI within 30 days of the date that the provider receives the FI's notice indicating the amount of overpayment identified by the RAC. Thereafter, further appeal may be made to the qualified independent contractor.

## Expansion

The RAC program expansion has begun. In the first phase of the expansion, each existing RAC is being authorized to audit claims in an additional state. To date, CMS has assigned Massachusetts to the New York RAC, Connolly Consulting, and South Carolina to the Florida RAC, Health Data Insights, Inc.; the additional state for the California contractor has not yet been identified. On July 1, 2007, the existing RACs began receiving claims data for the two new states as well as

additional claims data for existing states. On August 1, 2007, RACs will begin issuing medical records requests and improper payment letters to hospital providers in the new states. CMS plans to contract with four new RACs to act as auditors when the program has been implemented nationwide and anticipates that these new RACs will begin auditing providers by March 2008.

## Trends to date

During fiscal year 2006, RAC auditors identified $289.1 million in overpayments and $10.4 million in underpayments, and the Medicare program collected $68.6 million in overpayments and paid $2.9 million in underpayments. Roughly 85 percent of the 2006 RAC collections were identified by the New York and California RACs, who focused more on inpatient hospital claims; only 15 percent of recovered overpayments were identified by the Florida RAC, which initially focused on physician claims.

During the demonstration phase, the New York RAC's primary focus was on inpatient services related to debridement and respiratory system diagnoses and on outpatient services relating to blood transfusion services. In certain instances, Connolly Consulting issued demand letters on claims that had already been adjusted by other federal authorities.

The California RAC initially focused on inpatient acute care and later expanded to inpatient rehabilitation care. A major target area by the California RAC has been admissions to inpatient rehabilitation facilities ("IRFs"), particularly those involving lower extremity joint replacements. At least 25 facilities (approximately one-third of all IRFs in California) have been affected, with many facilities reporting a high volume of record requests, and all facilities reporting high denial rates (98 percent to 100 percent of charts reviewed). Recently, the California RAC has begun to review and deny claims for short stay admissions.

Over 2,500 RAC appeals were filed by providers in the three demonstration states in FY 2006. Some providers have received a determination from the FI upholding the RAC determination, but the vast majority of these appeals are pending. In May 2007, 36 California House members and Senator Feinstein wrote letters to CMS urging the agency to examine the RAC process to ensure fairness and accuracy with respect to medical necessity reviews and the appeals process.

## Next Steps

Providers who have not yet experienced a RAC audit should prepare by identifying high-risk and high-volume services and establishing a uniform process for responding to RAC audits. All providers should use the results of RAC audits to improve prospectively identified coding and documentation issues.

We will provide further updates as information becomes available. In the meantime, please contact your Ropes & Gray attorney with any questions.