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RAC Program to Move Forward - CMS Protest Dropped

Recent developments at the federal level have cleared the way for the permanent RAC program to move forward. On February 4, 2009, PRG-Schultz, USA Inc. and Viant, Inc, dropped their protest against CMS over the final RAC contract award process. Both PRG-Schultz and Viant were involved in the RAC demonstration project and filed a protest when they were not awarded a RAC contract for the permanent program. As part of the protest settlement both have been designated to serve as a subcontractor to one of the chosen RACs.

Now that the bid protests have been resolved, CMS is rescheduling the previously postponed outreach meetings. Participation in those meetings is recommended to ensure awareness of the policies surrounding the permanent RAC Program. Because there will likely be minor lag time between the outreach meetings and the first RAC request for records, providers should be taking steps to ensure their RAC teams are in place and ready. The following information is provided to assist providers in this effort.

Brief Review of the RAC Program and Demonstration Project

The RAC Program was instituted by CMS under authorization from the Medicare Modernization Act of 2003 and was made permanent under the Tax Relief and Health Care Act of 2006, Section 302. The Program was initiated under a three-year demonstration project beginning in 2005 that was first piloted in California, New York and Florida and was eventually implemented in Arizona, Massachusetts and South Carolina. A final RAC Demonstration report, released in June 2008, showed $1.03 billion in corrected Medicare payments. Of the total improper payments, $993 million (86%) were attributed to overpayments and $38 million (4%) were identified as underpayments. Almost $700 million was returned to the Medicare Trust funds. Of the payments recovered, 85% of the overpayments were recovered from inpatient hospital services, approximately 6% recovered from inpatient rehab services and 2% recovered from physician services. While individual hospitals were impacted differently, the RAC Demonstration Report indicated 33% of medical records resulted in overpayment collections.

In reviewing the demonstration project, there appear to be common areas that received RAC attention. With respect to error types, 40% of all improper claims were due to medical necessity, 35% were due to incorrectly coded claims and 8% due to insufficient documentation. Of particular interest to RACs were specific claims related to medical necessity. Under the medical necessity analysis, RACs audited surgical procedures

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Office Locations
Indiana Offices
One American Square
Suite 2000
Indianapolis, IN 46282
(317) 633-4884
Contact: Neal A. Cooper

8402 Harcourt Road
Suite 820
Indianapolis, IN 46260
(317) 871-6222
Contact: Stephan C. Masoncup

Kentucky Office
614 West Main Street
Suite 4000
Louisville, KY 40202
(502) 568-1890
Contact: Rene R. Savarise

Michigan Offices
Columbia Center, Suite 315
201 West Big Beaver Road
Troy, MI 48084
(248) 740-7505
Contact: Joan L. Lowes

2369 Woodlake Drive, Suite 280
Okemos, MI 48864
(517) 703-0921
Contact: Brian F. Bauer

Wisconsin Office
111 East Kilbourn Avenue
Suite 1300
Milwaukee, WI 53202
(414) 721-0442
Contact: Lori A. Wink

Contact Us
hallrender@hallrender.com

performed in the wrong setting, excisional debridement, cardiac defibrillator implant in the wrong setting and heart failure and shock treatment. In addition, another common area for RAC audits involved incorrectly coded respiratory system diagnoses requiring ventilator support.

Under the permanent program, the RACs will be paid a percentage of recovery for properly identified overpayments and underpayments. The RAC contingency fees are 12.45% for Region A, 12.50% for Region B, 9.00% for Region C and 9.49% for Region D. A map of the four regions can be viewed at:
http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf

Preparing for the RAC Audits

The RACs will likely have the full support of the Obama administration. In President Obama's February 24, 2009, address to Congress, he urged action to take on the high cost and waste of Medicare, specifically stating "We will root out the waste, fraud, and abuse in our Medicare program that doesn't make our seniors any healthier…"

With the RAC audit process poised to begin shortly, it is imperative that hospitals be proactive to ensure their RAC team and strategic plan is in place. In examining hospitals who participated in the RAC Demonstration Project, there are steps hospitals should take in preparing for a RAC response:

- Communicate and educate key staff members within the organization of the RAC program such as senior leaders, health information management, coding UR/case management, finance/reimbursement, compliance, medical staff and board of directors;
- Assemble a RAC response team and key leadership with staff members as noted above;
- Develop a standardized RAC response plan: identify who will be in charge and the point of contact for various aspects of the process-from receiving and tracking RAC requests, copying medical records, tracking the response and appeal timeline, to preserving an appeal issue;
- Review and prioritize assessment of high risk areas that could be subject to RAC audit such as areas related to medical necessity, high Medicare utilization, hospital-specific DRG analysis, outlier areas and patient admission and observation;
- Educate medical staff of the need to properly document and code areas identified as higher risk;
- Educate staff on the RAC response process.

Understand the RAC Claims Review and Appeals Process

Responding to a RAC audit or records request in a timely manner will be crucial to the RAC process. Hospitals should know their rights and the limitations placed upon RACs as a result of the permanent program implementation which differs from the demonstration project. Under the Claims Review Process, hospitals should be aware of the following:

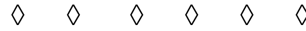
- RACs can only review claims from 10/1/07 forward;
- RACs must submit to CMS each new issue they wish to review and CMS must approve the RAC approach and regulatory standards; RACs must post new issues they intend to audit on their website; part of the Hospital RAC plan should be to check the RAC site frequently;
- Hospitals have 45 days to respond to a request for medical records - additional time can be requested if initiated before day 45 - if no response is provided to the RAC, the claim will be denied;
- RACs can only obtain a limited number of records for inpatient hospitals; RACs can only obtain 10% of average monthly Medicare claims (maximum of 200 records) every 45 days; for outpatient hospital or home health 1% of average monthly Medicare services (maximum of 200 records) every 45 days; records request limits will be based on provider NPI number - The AHA News reported on 10/21/08 that RACs cannot request more than a maximum of 200 records in a 45-day period for both inpatient and outpatient claims combined;
- RACs cannot review any claim or issue under review by the OIG or previously reviewed;
- RACs have 60 days to review records and must issue results to the provider by letter;
- If a RAC determines a denied claim/payment change is justified, the RAC will notify MAC/FI to begin recoupment process;
- A demand letter will be issued to the provider which will indicate the amount owed, the date interest accrues and appeal rights. Interest will begin to accrue from the date of the demand letter.

Appeal Rights Overview

Preserving appeal rights as the result of the RAC audit is an essential part of the RAC response process. If hospitals are engaged in a RAC review, it is crucial to follow an established timeline to help navigate the required procedural obligations. An abbreviated version of the appeals process is outlined below:

- Pre-Appeal - Providers should first notify the RAC of its dispute with the RAC's determination of an overpayment issue.
- Level 1 Review - Appeal to the FI/MAC for redetermination. The provider must file within 120 days of receiving the initial RAC determination letter requesting repayment; the MAC/FI has 60 days to issue a determination after the request is made.
- Level 2 Review - The provider has 180 days from the FI/MAC redetermination to file an appeal with a Qualified Independent Contractor; the QIC has 60 days to issue a determination after the request is made.
- Level 3 Review - If denied by the QIC, the provider must file an appeal within 60 days to an Administrative Law Judge. The ALJ has 90 days to issue a ruling.
- Level 4 Review - If denied by the ALJ, the provider must appeal within 60 days to the Medicare Appeals Council for review. The Appeals Council has 90 days to issue a determination.

- Level 5 Review - If denied by the Appeals Council, the provider must move within 60 days for judicial review in a United States District Court.



Hall Render is closely monitoring developments in this area and will provide future updates to clients. In the meantime, if you have questions regarding the RAC process, how to address a RAC response, challenge a RAC audit or how to preserve the hospital's appeal rights, please contact Joan Lowes, (248) 457-7857, Lori Wink, (414) 721-0456, Liz Elias (317) 977-1468 or Mark Douglas, (317) 977-1485 at Hall Render, Killian, Heath & Lyman, P.C.

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