

CLIENT ALERT

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RAC AUDIT PREPAREDNESS

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Starting this month, the Recovery Audit Contractor (“RAC”) Program conducted by the Centers for Medicare & Medicaid Services (“CMS”) will extend to New Jersey and Pennsylvania healthcare providers. This **Client Alert** discusses what the RAC Program is, what you can expect and what you can do to get ready.

BACKGROUND

As part of its enhanced efforts to identify improper Medicare payments, CMS has contracted with a private company, Diversified Collection Services (“DCS”), to act as the Recovery Audit Contractor in New Jersey and Pennsylvania. Through audits, DCS will identify overpayments and underpayments. DCS is paid by CMS on a contingency fee basis on both the overpayments and underpayments that it finds. Under the law as it presently exists, the RAC Program will be permanent. If you bill fee-for-service programs, your claims will be subject to review by the RACs.

Using the same Medicare policies as used by the Carriers, Fiscal Intermediaries (“FIs”), and Medicare Administrative Contractors (“MACs”), RACs review claims on a post-payment basis. RACs may look back three years prior to the date the claim was paid, but will not be able to review claims paid prior to October 1, 2007.

The RACs engage in two types of reviews: (i) automated (no medical record review conducted), and (ii) complex (medical record required). There are limitations on the number of records that the RAC can request, which vary depending on the size of the practice. Automated reviews may be used (i) when there is certainty that the service is not covered or is incorrectly coded and (ii) when a written Medicare policy, Medicare article or Medicare-sanctioned coding guideline exists. RACs may also use automated reviews when making other determinations (e.g., duplicate claims) when there is certainty that an overpayment or underpayment exists. This is premised on the rationale that written policies and guidelines often do not exist for these situations. Where the RAC identifies a “clinically unbelievable” issue (i.e., a situation where certainty of non-coverage or incorrect coding exists but no Medicare policy, articles or guidelines exist), the RAC must seek CMS approval to proceed with automated reviews.

The RAC will send a findings letter as to each automated review that results in an overpayment determination, and as to every complex review, regardless of whether an improper payment was identified. At that point, the normal appeals process applies with regard to deadlines for repayment, recoupment and appeal; with the first level of appeal being to the FI, Carrier or MAC, as the case may be, and not to the RAC.

Complex reviews involving medical records are not expected to begin until October or November of this year. Reviews that include a focus on medical necessity are not expected to begin until next year.

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What is different about the RAC process is that the RAC offers an opportunity for the provider to discuss the improper payment determination with the RAC and to submit accompanying evidence to support the provider's case. Every provider should take advantage of this opportunity, while keeping in mind (so as not to lose sight of appeal deadlines) that this discussion opportunity is outside the normal appeals process. What is also unique about the RAC process is that before it can begin auditing issues, those issues must be approved by CMS and posted to the RAC website. Also before the audits begin, provider outreach must be held in the affected state. On July 14, 2009, a telephone conference, coordinated by the Medical Society of New Jersey, was held and included CMS and DCS spokespersons. This telephone conference, according to the speakers, satisfied the required provider outreach activities for New Jersey.

WHAT PROVIDERS CAN DO TO GET READY

Make sure your "house is in order," or, as CMS expresses it, conduct an "internal assessment to ensure that submitted claims meet the Medicare rules." Because it is sometimes difficult to be objective when assessing yourself and your practice, it may be useful to utilize an outside consultant that engages certified procedural coders to review a reasonable sampling of records and billings. If the consultant is engaged by legal counsel to assist in providing legal advice and services, the attorney-client privilege may attach to the consultant's communications and add a heightened level of confidentiality. This outside review or pre-RAC internal audit can be done affordably on a fixed fee basis. Based on the results of this outside review or pre-RAC internal audit, the practice can identify whether its physicians are documenting and billing in compliance with the Medicare rules. This also creates the opportunity to implement corrective actions to achieve compliance so that the RAC audit will not find improper payments. To the extent that the RAC audit reviews claims that pre-date the practice's internal audits, the results of internal audits will enable the practice to be in a better position to quickly rebut the RAC's findings during the discussion period and to determine whether an appeal is warranted.

Look to see what improper payments were found by the RACs by reviewing the demonstration findings at www.cms.hhs.gov/rac and checking for permanent RACs' findings which will be listed on the RACs' websites. In addition, CMS suggests that it would be helpful to see what improper payments have been found in the Office of Inspector General ("OIG") and Comprehensive Error Rate Testing ("CERT") reports. The OIG reports can be found at www.oig.hhs.gov/reports.asp and the CERT reports can be found at www.cms.hhs.gov/cert.

Keep track of denied claims to see if any patterns exist, and correct these previous errors.

Use this time as an opportunity to develop, with the assistance of legal counsel, an overall billing and compliance program or to update your existing program. The OIG has recognized such programs as an important way to prevent erroneous, improper or fraudulent conduct and avoid the serious ramifications of such conduct which extend beyond simply repayment of overpayments.

Appeal when necessary. If you have questions, contact your attorney upon receipt of a RAC issued demand letter so that you can be guided as to what is required in order

to perfect an appropriate appeal. Because appeal deadlines begin to run, prompt assessment and guidance is necessary. Legal counsel may also help you assess and analyze the merits of the RAC findings and assist you with regard to your communications with the RAC during the RAC discussion period. Because this discussion period begins when you receive the demand letter, prompt action is also necessary before the discussion period expires.

With our knowledge of the RAC and appeals process and experience handling audits and reimbursement issues, we stand ready to assist you at all points of the RAC continuum.

If you would like additional information about the issues addressed in this CLIENT ALERT, please contact:

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