Preparing for a RAC Audit and Appeal

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An effective strategy for responding to an audit by a Recovery Audit Contractor (RAC) and appealing its allegations of an overpaid Medicare or Medicaid claim will require both preparation and diligence. Through section 302 of the Tax Relief and Health Care Act of 2006, Congress converted a Medicare demonstration project into a permanent institution by 2010. In addition, section 6411 of the Affordable Care Act of 2010 expanded the RAC's jurisdiction to Medicaid programs. Compensated on a contingency-fee arrangement, these bounty hunters are tasked to identify overpayments (and underpayments) throughout the country.

The following checklist is designed to assist practitioners who represent Medicare fee-for-service providers or suppliers in RAC audits and appeals. Because the Medicaid RAC audit and appeal procedures may vary from state to state, the requirements of the applicable state Medicaid agency should be reviewed. Nevertheless, this checklist should be generally applicable to Medicaid audits and appeals as well because the fundamental structure and elements of the Medicare and Medicaid RAC programs are similar.

Before the RAC Attack Begins

□ Designate an office or official at the provider or supplier as the contact for the RACs.

□ The in-house RAC team or coordinator should be responsible for conducting, documenting, and tracking all communication with the RACs.

□ Ensure that the local RAC has the provider's or supplier's full and correct contact information.

Comment: There are five Medicare RACs:

Region 1: Performant Recovery, Inc. (https://www.performantrac.com/) – Connecticut, Indiana, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New York, Ohio, Rhode Island, and Vermont.

Region 2: Cotiviti, LLC (www.cotiviti.com) – Arkansas, Colorado, Illinois, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Oklahoma, Texas, and Wisconsin.

Region 3: Cotiviti, LLC (www.cotiviti.com) – Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, Puerto Rico and U.S. Virgin Islands.

Region 4: HMS Federal Solutions (www.hms.com) – Alaska, Arizona, California, District of Columbia, Delaware, Hawaii, Idaho, Maryland, Montana, North Dakota, New Jersey, Nevada, Pennsylvania, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, and Northern Marianas.

Region 5: Performant Recovery, Inc. (https://www.performantrac.com/) – Nationwide for DMEPOS suppliers, home health agencies and hospices.

□ Establish RAC policies and procedures.

□ The protocols should identify the in-house departments to contact (e.g., records, compliance, and legal) and describe the process for handling the requests for medical records and preparing the appeal.

□ The provider or supplier may wish to include in its RAC protocols a process for establishing measures to prevent similar errors identified by the RACs from occurring again in the future or for coordinating with its corporate compliance plan.

□ The provider or supplier may wish to test its protocols with a dry run to identify inadequacies and improve the process.

□ Monitor and review the CMS (www.cms.gov/rac) or the state Medicaid agency and local RAC websites for any updated list of issues or services subject to audit as well as major findings by the RACs.

When RAC Attacks

□ Log the requests for medical records for tracking purposes.

Comment: Please note that the Medicare RACs may not always request medical records prior to issuing their findings (for automated reviews as opposed to complex reviews).

□ Confirm that each issue or service being audited has been approved by CMS (or the state Medicaid agency).

□ Confirm that the number of medical records requested does not exceed the limit established by CMS (or the state Medicaid agency) for the provider or supplier type.

Comment: Please note that CMS may not only change the limits but also approve requests from RACs to exceed the limits.

□ Confirm that the maximum number of records is requested only once within the established time period (every 45 days for Medicare). For example, a Medicare RAC may not exceed the limit by skipping a 45-day period.

□ Confirm that the payment dates of the claims being audited fall within the established look-back period (3 years from the date of claim adjudication for Medicare).

□ Locate, gather, and paginate the requested medical records.

□ Submit the medical records to the RAC within the requested time frame.

□ Confirm that the RAC has received the medical records and follow up as necessary.

> **Comment:** Please note that reimbursement for each page photocopied (12 to 15 cents per page) and first class mail may be available for certain types of Medicare providers and suppliers not reimbursed on a reasonable cost-basis.

□ Log the dates of submission and receipt of the medical records.

When the RAC Demands a Refund (After an Automated Review) or Issues Its Unfavorable Findings (After a Complex Review)

□ For complex reviews, confirm that the RAC has completed its review of the medical records within the established time frame (30 days from the date of receipt for Medicare).

□ Log the receipt of the RAC letter.

□ Determine whether the RAC should be contacted to discuss its findings (e.g., a particular medical record was inadvertently not submitted). For Medicare, this physician-to-physician Discussion Period is separate from the appeal process and is available up to 30 days from the receipt of the RAC letter.

□ Determine whether the audit findings should be appealed.

- □ Ensure that the standard Medicare form is completed for filing with the appeal or that the custom Appointment of Representative document complies with 42 C.F.R. §405.910.

- □ A Request for Redetermination must be submitted to the local Medicare contractor within 120 days from the receipt of the demand letter.

  - □ Ensure that the standard Medicare form is completed or that the appeal document complies with 42 C.F.R. §405.944.

  - □ Log the dates of filing and receipt.

  - □ Follow up and document if a decision is not issued within 60 days.

- □ A Request for Reconsideration must be submitted to the local Qualified Independent Contractor (QIC) within 180 days from the receipt of the unfavorable Redetermination Decision.

  - □ Ensure that the standard Medicare form is completed or that the appeal document complies with 42 C.F.R. §405.964.

  - □ Ensure that all documentary evidence to be included in the record is submitted to the QIC.

  - □ Log the dates of filing and receipt.

  - □ Follow up and document if a decision is not issued within 60 days.

  - □ Determine whether inaction by the QIC should be escalated to an Administrative Law Judge pursuant to 42 C.F.R. §405.970.

- □ A Request for ALJ Hearing must be submitted to the Office of Medicare Hearings and Appeals within 60 days from the receipt of the unfavorable Reconsideration Decision.

  - □ Ensure that the amount in controversy requirement is satisfied ($160 for Medicare in 2017). 81 Fed. Reg. 65651 (09/23/2016).

  - □ Ensure that the standard Medicare form is completed or that the appeal document complies with 42 C.F.R. §405.1014.

  - □ Ensure that the Certificate of Service is complete and complies with HIPAA.

  - □ Log the dates of filing and receipt.

  - □ Follow up and document if a decision is not issued within 90 days.

  - □ Determine whether inaction by the ALJ should be escalated to the Medicare Appeals Council (MAC) pursuant to 42 C.F.R. §405.1106.

- □ A Request for Review must be submitted to the MAC within 60 days from the receipt of the unfavorable ALJ decision.

□ Ensure that the standard Medicare form is completed or that the appeal document complies with 42 C.F.R. §405.1102.

□ Ensure that the Certificate of Service is complete and complies with HIPAA.

□ Log the dates of filing and receipt.

□ Follow up and document if a decision is not issued within 90 days.

□ Determine whether inaction by the MAC should be escalated to the applicable U.S. District Court pursuant to 42 C.F.R. §405.1132.

□ A Complaint must be submitted to the applicable U.S. District Court within 60 days from the receipt of the unfavorable MAC decision.

□ Ensure that the amount in controversy requirement is satisfied ($1560 for Medicare in 2017). 81 Fed. Reg. 65651 (09/23/2016).

□ Ensure that the action complies with 42 C.F.R. §405.1136.

□ Determine whether the overpayment should be refunded, recouped, or temporarily stayed pending the appeal.

□ Interest will not accrue if the overpayment is refunded within the established time frame (30 days for Medicare). If successfully appealed, interest will not be paid when the refund is returned to the provider or supplier.

□ Interest will accrue while the overpayment is being recouped by the provider's or supplier's local Medicare contractor. If successfully appealed, interest will be paid when the recouped amount is returned to the provider or supplier.

□ Recoupment will not be initiated when—

□ a Request for Redetermination is filed within 30 days after the receipt of the demand letter.

□ a Request for Reconsideration is filed within 60 days after the receipt of the Redetermination Decision.

□ Recoupment will be stopped when—

□ a Request for Redetermination is filed between 31 and 120 days after the receipt of the demand letter.

□ a Request for Reconsideration is filed between 61 and 180 days after the receipt of the Redetermination Decision.

□ Recoupment will either commence or resume after an unfavorable Reconsideration Decision is issued.

Additional Resources

For additional resources related to RAC audits, see:

- Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69037 (11/10/10)
- BNA's Health Care Fraud Report, "HHS Agency Suspends New Medicare Appeals For Two Years, Citing Surge in Appeal Filings," (18 HFRA 63, 1/22/14)(18 HFRA 63, 1/22/14)
- BNA's Medicare Report, "RAC Record Requests Up 13 Percent Between First, Third Quarters of 2013,"(17 HFRA 1029, 11/27/13)
- BNA Insights, "Recovery Audit Contractors as Whistleblowers: How Medicare and Medicaid Auditors Can Receive a "Double Kickback" From the Government as Qui Tam Plaintiffs," by Joel R. Levin and Charles W. (Chip) Mulaney (20 HLR 82, 1/13/11)
- BNA's Health Law Reporter, "Hospitals Facing RAC, Other Program Audits Urged to Have Defensive Strategies in Place" (19 HLR 1201, 8/26/10)
- BNA's Health Care Fraud Report, "Providers Should Prepare Now For Responding to RACs, Experts Say" (13 HFRA 712, 9/23/09)

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