How to Prepare for RAC Audits Related to Alleged Fraudulent Billing

Michael Denbow, *Member*
Ameena Khan, *Attorney*

STITES & HARBISON ATTORNEYS

1

Where did the RAC audit come from?

- 42 U.S.C. § 1395ddd provides:

  "Under the Program, the Secretary shall enter into contracts with **recovery audit contractors** in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this subchapter with respect to all services for which payment is made under this subchapter."

2

What does an RAC do?

- A third-party entity working on behalf of the United States government Centers for Medicare and Medicaid Services to identify and recover improper payments made in Medicare transactions between providers and payors.
- These improper payments are identified via audits, commonly referred to as RAC audits.
- **Note**: RACs work specifically within Medicare audits. There are third party audit organizations that perform audits for insurance companies, but those are not referred to as RAC or MAC audits.

3

History of RAC Audits

2005 – 2010	• In 2005, Congress authorized the Centers for Medicare & Medicaid Services (CMS) to initiate the Recovery Audit Contractor (RAC, now RA) program. • Began with three states: New York, Florida, and California • By 2007, $693.6 million in improper payments
2010 – 2018	• In 2010, due to its access, program expanded nationwide • After the initial five-state demonstration, 96% of improper payments found were overpayments on behalf of CMS, authorizing them to recover hundreds of millions in funds • Just 4% were underpayments remitted back to providers
2018 – Present	• CMS re-launched the RAC audit program in 2018 with new rules and guidelines for audits • Fewer audits with fewer document requests per audit

STITES & HARBISON ATTORNEYS

4

Current state of RAC audits

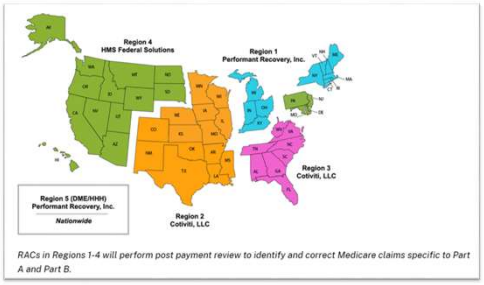
RACs perform audits of many types of Medicare providers including:

- Hospitals
- Physician practices
- Nursing homes
- Home health agencies
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Any provider or supplier that submits claims to Medicare

Note: Providers that are outliers for certain types of claims may prompt an audit. For example, a provider who consistently bills a higher level of services than the provider's peers in the same geographic area may trigger a RAC audit. Providers with low claim denial rates are less likely to be audited.

STITES & HARBISON ATTORNEYS

5



RACs in Regions 1-4 will perform post payment review to identify and correct Medicare claims specific to Part A and Part B.

Medicare Fee for Service Recovery Audit Program | CMS

STITES & HARBISON ATTORNEYS

6

RAC Audits and Fees

- CMS uses private contractors
- Paid on a contingent basis, calculated on a percentage of what can be recovered from a Medicare provider
- Incentivizes an aggressive approach and coverage
- Fees vary from state to state: between 9% and 12% on every dollar recovered

7

The RAC Audit Process

- Scope of RAC Audit
- Types: Automated vs. Complex
- Steps of the Process

8

Scope of an RAC Audit

- Flagging and correcting improper Medicare payments
- Collecting overpayments for services provided to Medicare beneficiaries
- Identifying underpayments so CMS, Carriers, and MACS, can implement actions to prevent future improper payments
- 3 year look back period. *See* 42 CFR 455.508.

9

Type of Audit

Automated

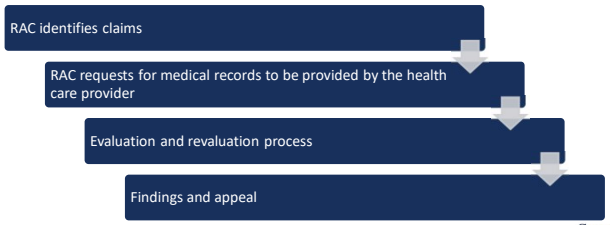
- An automated review relies on an analysis of claims data to make a determination
- Automated reviews are generally based on clear policies outlined in the law, regulations or guidance

Complex

- Requires more in-depth analysis and often involves a request for medical records from the contractor
- May involve questions of medical necessity, proper documentation, and others where judgment is required

10

RAC Audit Process



11

Best practices

- Provider must timely and affirmatively respond to any audit or investigation by Medicare of Medicaid contractor as there are a number of potential adverse outcomes and consequences that can result from the audit or investigation including:
  - prepayment review, payment suspension, revocation of Medicare/Medicaid billing privileges, referral to the OIG or other law enforcement agencies , and potential exclusion from Medicare and Medicaid programs

12

I received a request for records—What now?

- Establish an office procedure
- Provider should review the patient's entire medical record
- Make sure that ALL of the relevant records are provided to the RAC
- Bates number
- Maintain copies
- Data sheet/table of contents to accompany documents
- A memorandum explaining why the billing was compliant with program requirements

13

When receiving a document request DO NOT:

- Ignore it
- Send incomplete files
- Create a missing document or alter/amend an existing document
  - Risk of criminal prosecution for obstruction of justice
  - Supplement with memorandum/more legible document instead

14

RAC Issues a Determination

Once a determination is made, a formal letter is sent to the practice generally detailing:

- The coverage, coding, or payment policy in violation;
- The reason for the review;
- A description of the overpayment;
- Recommended corrective actions;
- An explanation of the physician's right to submit a rebuttal statement prior to recoupment of any overpayment;
- An explanation of the procedures for recovery of overpayments;
- Notification of the physician's right to request an extended repayment schedule; and
- Information on the physician's right to appeal.

15

How Do You Appeal an RAC Determination?

The Five Levels of an RAC Appeal

16

Level 1: Redetermination

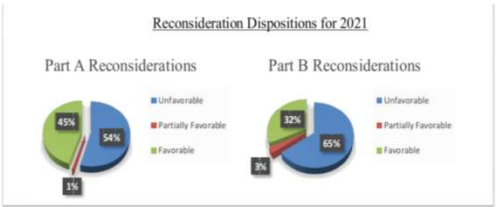
- As a provider, you must file a request for redetermination within 120 days from the date of receipt of the initial determination.
- Must be in writing
- A decision will typically be issued within 60 days of receipt. 42 CFR 404.940–.958.

17

Level 2: Reconsideration

- You have 180 days of receipt of the redetermination decision to appeal to the second level.
- Request must be filed in writing
- Request will be reviewed and decided by a Qualified Independent Contractor (QIC).
  - A decision is typically issued within 60 days of receipt. 42 CFR 405.960–.978.

18



First Level of Appeal: Redetermination by a Medicare Contractor | CMS

19

Level 3: Administrative Law Judge (ALJ) Hearing

- The review is conducted by an ALJ judge within the Office of Medicare hearing and Appeals (OMHA).
- You must request a hearing within 60 days of receipt of the Reconsideration decision letter.
- Hearings are generally held by videoconference or telephone, though you may request it to take place in person. However, the ALJ may come to a judgement without testimony if there is "sufficient information."
- This level of appeals is only available to you if the amount in controversy after the QIC decision is over a certain amount. The Judge will issue a decision within 90 days. 42 CFR 405.1000–.1058.

20

Helpful tip: Consider aggregating claims

An individual appellant can aggregate two or more claims for an ALJ hearing if:

- (a) The claims were previously considered by a QIC
- (b) The appellant requests aggregation of claims appealed in the same request for ALJ hearing, or in multiple requests for an ALJ hearing filed with the same request for aggregation, the request is filed within 60 calendar days after receipt of the reconsiderations being appealed; and
- (c) The claims that a single appellant seeks to aggregate involve the delivery of similar or related services. 42 CFR 405.1006(e).

21

Level 4: Review by the Medicare Appeals Council

- File your written request for Council review within 60 days of receipt of the ALJ's decision
- Decision within 90 days
- If the Council cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to U.S. District Court.

22

Level 5: Judicial Review in U.S. District Court

- You have 60 days from receipt of the Council's decision – or after the Council ruling timeframe expires – to request judicial review.
- You may only request a judicial review if "amount in controversy" is above $1,760.
- The U.S. District Court will make the final decision.
  - The findings of fact made by the Medicare Appeals Council are deemed conclusive if supported by substantial evidence in the record. 42 CFR 405.1136–.1140.

23

Harsh Penalties

- OIG Sanctions 42 U.S.C. 1320(a)–7(a).
- Exclusions from Medicare, Medicaid, and other federal health care programs
- Medicare and Medicaid Payment Suspensions. 42 CFR 405.371.
- A health care related conviction or even abusive billing practices can result in Medicare and/or Medicaid terminating an individual or entity's provider agreement, in turn terminating billing privileges.
- Once revoked, CMS can prohibit re-enrolling for up to 10 years

24

RAC Audits and Litigation

25

False Claims

- If auditors determine that a provider has intentionally or systematically overbilled Medicare, then they may choose to refer the provider to CMS, the U.S. Department of Justice (DOJ), or the U.S. Department of Health and Human Services' Office of Inspector General (HHS OIG) for possible civil or criminal prosecution

26

Search Warrants

- This should be something that is incorporated into employee training
- Identify the individuals – request to see business cards/badges
- Immediately request to speak to the legal department (or outside counsel) – BEFORE SPEAKING ABOUT ANYTHING
- Try to remain calm/be polite, but always remember that you have Constitutional Rights and you should not be afraid to exercise them
- STATUS: Target
- NEXT STEP: Internal investigation – investigate the investigation

27

Grand Jury Subpoenas

- Sometimes comes with a personal visit to interview employees – voluntary and should be declined
- Determining the status of the client is of paramount importance – it will inform all next steps
- Determining the scope of the subpoena
  - What does the client actually have?
  - What is actually relevant?
  - What can be done on a rolling basis/narrowed?
- Litigation hold/IT preservation – no obstruction of justice
- Internal investigation?

28

Civil Matters

- Come in many, many different forms:
  - Civil false claims act subpoena
  - CIDs
  - Regulatory audits
  - Chart reviews
- May seem benign – must be vigilant
- Can be the start of a more serious investigation
  - Whistleblower
  - Separate subject matter (e.g., chart review for X turns into investigation into Y)
  - Poor performance on audits/documentation
- Don't overreact, but remain skeptical
  - Review any communications/responses/documents with bigger picture in mind

29

Practical Recommendations

- If you receive a letter from a RAC notifying you of a recovery, do not panic
- Because RAC audits are a potentially dangerous starting point for costly recoupment or further Medicare fraud investigation, it is strongly recommended providers seek the assistance of experienced and qualified health and medical law attorneys at this stage
- Conducting an Internal (and Attorney-Client Privileged) Medicare Billing Compliance Audit
- Know what to do if the government comes knocking
- Stay ahead of RAC audit issues through internal policies and audits

30

Resource Links

- Approved RAC Topics | CMS
- First Level of Appeal: Redetermination by a Medicare Contractor | CMS
- Fraud and Abuse Investigation Handbook for the Health care Industry (Second Edition), AHLA (2021).
- Medicare Fee for Service Recovery Audit Program | CMS
- Resources | CMS
- Recovery Audit Contractor (RAC) Program - CMS RAC Resources | AHA
- 42 C.F.R. § 405.900-405.1140
- 42 U.S.C. § 1395ddd

Other helpful resources can be found at: https://www.cms.gov/

31

Contact Information

Michael Denbow
STITES & HARBISON, PLLC
502.681.0394
mdenbow@stites.com

Ameena Khan
STITES & HARBISON, PLLC
502.681.0520
akhan@stites.com

32