Recovery Audit Contractor (RAC) Coming Soon to Washington: Are You Ready to Handle Medical Record Request Audits?

By Mary Re Knack
Healthcare Attorney and Member
Williams Kastner

and

By Arissa M. Peterson
Healthcare Attorney and Associate
Williams Kastner

The Department of Health and Human Services (HHS) must implement a permanent, national Recovery Audit Contractors (RAC) program by January 1, 2010. The program is expected to be underway in Washington by August 2009, with HealthDataInsights, Inc. (HDI) assigned as the contractor.

The purpose of the RAC program according to the Center for Medicare and Medicaid Services (CMS) is to reduce improper Medicare payments through the efficient detection and collection of overpayments, including Non-Medicare Secondary Payer overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments. CMS has concluded the RAC demonstration program that began in 2005 was a cost-effective success. RACs discovered over $1 billion in improper payments, 85% recovered from hospitals, during the demonstration program at a minimal cost to the government. While RACs also identify underpayments, the demonstration program revealed that 96% of claims were overpayments. Thus, the clear focus of the program is to identify and correct Medicare fraud and abuse.

There are two kinds of RAC audits – automated and medical record reviews. Automated reviews utilize RAC's proprietary software to discover obvious billing errors. The majority of audits performed are medical record audits where the RAC requests medical records to audit.

Once the program is underway, providers will need to respond to record requests in an effective and timely matter. Eight percent of the total denials during the demonstration program involved failure to respond timely to RAC requests for records. Therefore, providers are well-advised to begin preparing now to respond to record requests and to implement effective response and compliance programs.

Under the permanent program, a provider must provide medical records within 45 days of the request, although the provider may request an extension. In late October, CMS announced medical record request limits based upon the type of provider. These medical record request limits are available for download at http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp. Providers may want to become familiar with these limits now before receiving the first RAC request letter. For example, for an inpatient hospital, RAC may request ten percent of average monthly Medicare claims (max of 200) per 45 days. This is still a considerable number of medical record requests that can be made within a short period of time.

To prepare, it is recommended that providers form a RAC response team that will implement an efficient process to handle record requests tailored to the provider's individual needs. As processes to handle RAC requests for records, the response team may want to consider: (1) logging the RAC's request in an automated system, noting the deadline and evaluating whether an extension may be nec-

essary; (2) copying the patient's complete medical record; (3) submitting copies of medical records to RAC by the deadline; (4) maintaining duplicate paper and electronic copies of every medical record request sent to RAC; (5) tracking receipt of documentation by RAC; (6) tracking the deadline for the RAC determination (60 days from receipt of the medical record); (7) tracking the outcome of the RAC review; and (8) tracking the deadline to appeal the RAC decision (120 days from receipt of the decision).

Providers may also want to review their medical records management system to determine where older medical records are stored, since going forward the look-back period is three years, with a maximum look-back of October 1, 2007. For medical records stored off-site, providers may want to evaluate now how those records will be accessed and how long it will take to access them. Providers may also want to determine if they will have an internal or external group review the records and perform a "mirror" audit on the records, or whether they will wait to get the RAC results. Retrospective and proactive audits should be conducted periodically, especially on any RAC overpayment determinations.

The RAC must complete the review of the medical record and issue a determination within 60 days from receipt. Providers may then appeal a RAC determination by following the Medicare appeal rules, which require appeals to be filed within 120 days. Providers should consider identifying a point-person to handle the appeals process and evaluate now whether to involve outside legal counsel in the appeals process. CMS has indicated that one of the successes of the three-year demonstration program was that providers do not appeal every overpayment determination; therefore, providers should consider whether they want to institute a vigorous appeal program. The benefits of appealing RAC determinations were discussed in the December 2008 issue, "OIG Holds Hospital Boards Accountable on Fraud Audits," by Donna Herbert, Vol. 3, Issue 12, at 1-2.

Mary Re Knack and Arissa M. Peterson are healthcare attorneys with the Williams Kastner law firm. Williams Kastner (www.williamskastner.com) has been serving clients in the Northwest since 1929. The writers can be contacted by email at mknack@williamskastner.com or apeterson@williamskastner.com, respectively.