Prepare for Increased RAC Activity in 2011

Andrew B. Wachler, Esq. and Jennifer Colagiovanni, Esq.
Wachler & Associates, P.C.

A review of the ever-changing audit landscape suggests that providers should be prepared for increased Recovery Audit Contractor (RAC) activity in both the Medicare and Medicaid programs in 2011. Of particular importance is the expansion of the RAC program to Medicare Parts C and D and Medicaid, pursuant to the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act mandates the expansion of the RAC program to Medicare Part C (Medicare Advantage plans) and Part D (Prescription Drug coverage) by December 31, 2010. This is also the date by which states are required to have contracted with one or more RACs to perform audits of Medicaid providers. States are expected to implement their RAC programs by April 1, 2011. CMS recently issued a letter indicating that state Medicaid Directors need to submit a State Plan Amendment (SPA) to CMS which either attests that the state will establish a Medicaid RAC program by December 31, 2010, or that the state will seek an exemption from the requirements. CMS has indicated that exemptions will only be granted under the most compelling circumstances.

States are also required to have an adequate appeals process in order to handle appeals from adverse audit decisions made by the Medicaid RACs. So long as a state's existing administrative appeals process, such as one used to handle Medicaid Integrity Contractor (MIC) appeals, is able to accommodate Medicaid RAC appeals, CMS is not requiring states to adopt a new administrative review process. It is important to note that the Medicaid RAC program is *in addition to*, not in place of, the Medicaid Integrity Program and the audits conducted by the MICs. Because of these multiple programs, Medicaid providers are faced with a greater likelihood of audits in the upcoming year.

Providers are also more likely to be faced with significant RAC audits in the upcoming months due to the recent addition of medical necessity reviews in all four RAC regions. Medical necessity reviews allow the RACs to apply a subjective standard to various services and thus create increased risks for all providers – even those who believe they are billing and coding appropriately. The RACs have been steadily increasing the number of procedures and issues subject to medical necessity reviews. During the RAC demonstration project around 50 percent of the identified overpayments were related to medical necessity issues. It logically follows that medical necessity reviews will continue to be a highly targeted area by the RACs, as is evident by the recent approval of five additional, potentially broad medical necessity approved issues in Region C. These approved medical necessity reviews may also implicate the issue of outpatient reimbursement for inpatient denials.

In addition to expanding the RAC program, the Affordable Care Act also creates new risks for false claim liability when auditors identify overpayments. The Affordable Care Act amended federal law to require that an entity who has received an overpayment must return the overpayment and notify the appropriate entity (such as CMS, OIG, or the carrier) regarding the reason for the overpayment. This must occur no more than 60 days from "the date on which the overpayment was identified" or "the date any corresponding cost report is due, if applicable."

Retention of an overpayment beyond this deadline creates liability under the False Claims Act (31 U.S.C. §3729).

These changes raise many issues for those in the RAC audit process including:

- Does a negative appeal determination create an overpayment which must be paid back in 60 days?
- What are the responsibilities for a provider who realizes during the audit process that they received an overpayment?
- What is the potential liability for a provider who cannot afford to pay back the overpayment?

There has yet to be clarification from the Office of the Inspector General (OIG) as to many issues surrounding this legislation, including when the overpayment return obligations are triggered during the audit process. Although the appeals process will likely provide protection from an audit finding being deemed a "known" overpayment, there is some level of risk that the OIG could prosecute individuals and entities who do not timely repay overpayments under the False Claims Act, especially if there is no good faith basis for appeal, e.g., no documentation to support the services provided.

False Claims Act liability is significant. Possible penalties include civil money penalties of $10,000 for each item or service, an assessment of three times the amount claimed for each item or service and exclusion from participation in the federal health care programs as well as any state health care programs. Moreover, the mere failure to repay an overpayment (even without False Claims Act liability) can lead to exclusion from the Medicaid program.

As a result of these changes, it is important for entities in the RAC audit process to carefully consider whether, at any stage of the process, the facts show a known overpayment. If so, the entity should discuss with legal counsel its obligation to promptly pay back the known overpayment or risk prosecution under the False Claims Act. Also, providers should be aware of this repayment obligation once the appeals process has been exhausted or abandoned by the provider.

After a year of audit expansion, providers can expect to see increased audit activities as we move into 2011. Providers are advised to proactively prepare for audit activities, develop an effective process to appeal audit claim denials, and evaluate the risks and potential penalties related to the retention of a Medicare or Medicaid overpayment.