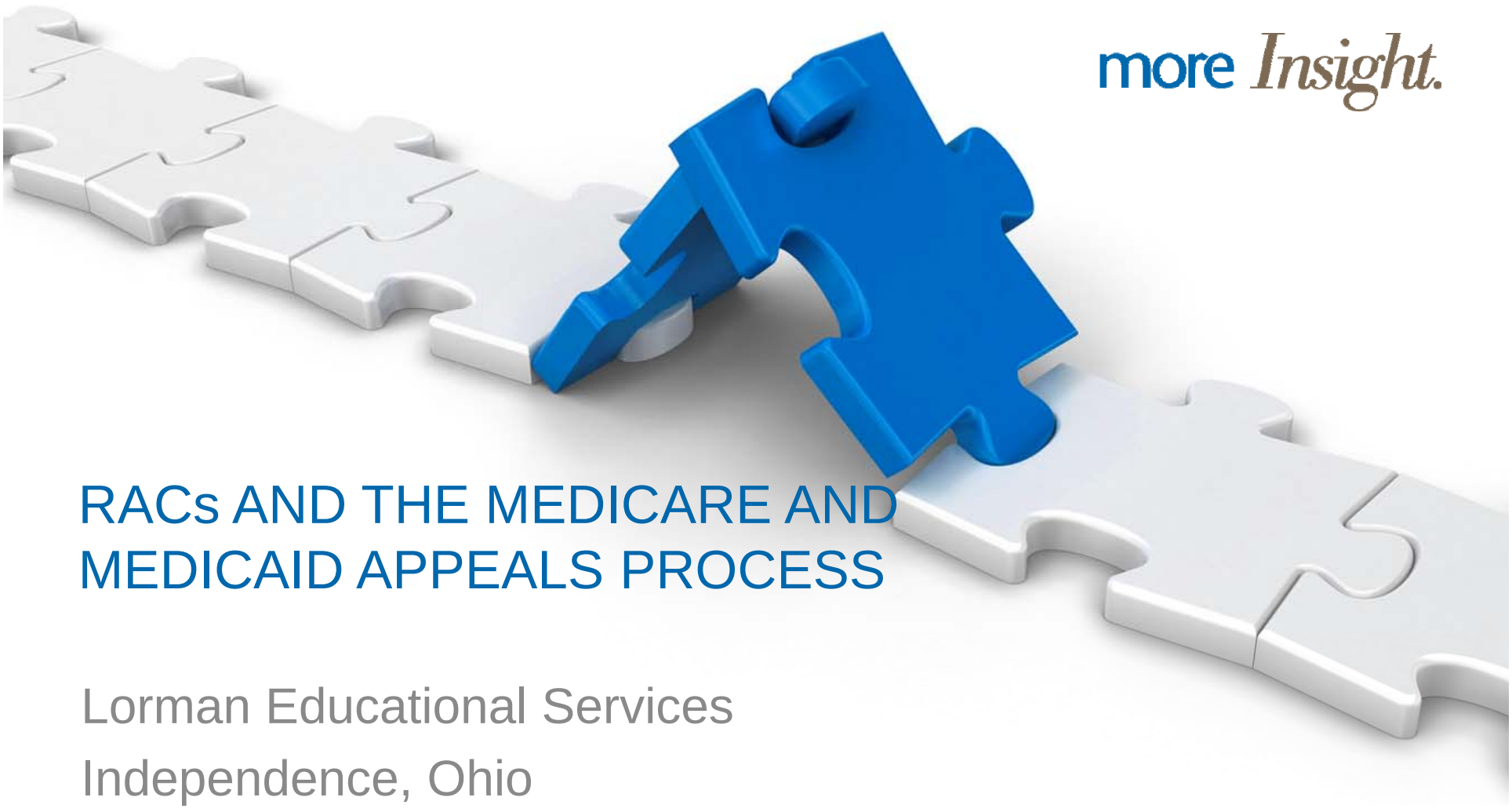


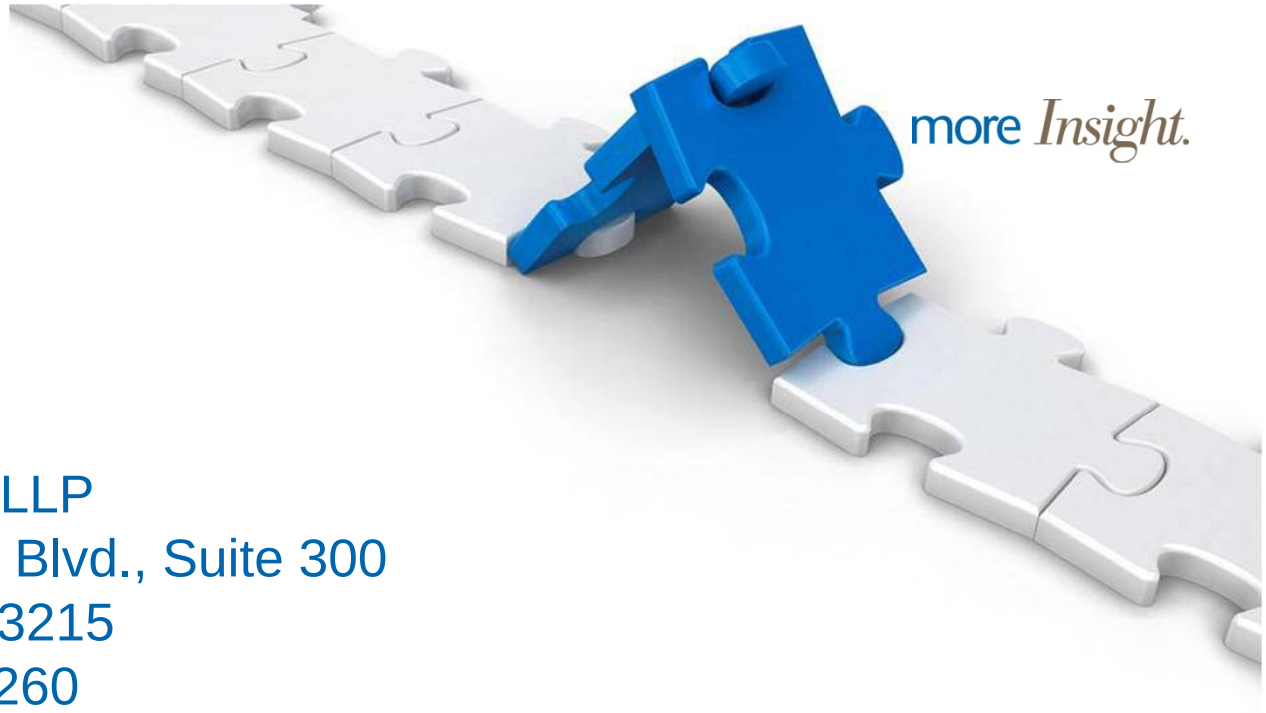
more Insight.

RACs AND THE MEDICARE AND MEDICAID APPEALS PROCESS

Lorman Educational Services

Independence, Ohio

Dinsmore



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Background

It's About Minimizing Improper Payments: CMS is vocal about its focus on minimizing improper payments. The common types of improper payments involve services that:

- lack medical necessity
- are improperly coded
- lack sufficient documentation

The admission has to be appropriate, necessary and reasonable.

The service has to be appropriate, necessary and reasonable.

Background

Goals of the RAC Demonstration:

- use third-party companies
- pay contingency fees to those companies for identifying and correcting improper payments (**overpayments** *and* **underpayments**)

Where the RAC Demonstration Occurred:

CMS selected three RACs that reviewed fee-for-service claims in California, Florida, and New York over a three-year period.

Understanding the RAC Program: Identifying and Returning *Underpayments*

Automated & Complex Reviews: RACs will use automated and complex reviews of medical records to identify Medicare underpayments. Any underpayment findings on claims will be communicated to the affiliated contractor.

You Will Receive a Letter and Get Paid: The affiliated contractor will validate the RAC's underpayment finding through the RAC Validation Contractor. Once validated, an "Underpayment Notification Letter" will be sent to the provider. The relevant contractor will adjust the claim and be responsible for paying the provider. If there is also a corresponding overpayment determination, those amounts will offset the underpayment adjustment.

Understanding the RAC Program: Identifying and Collecting *Overpayments*

Automated and Complex Reviews: RACs will also use automated and complex reviews of medical records to identify Medicare overpayments.

Limited Scope of Review: CMS has excluded several potential sources of improper payments from RAC scrutiny, including:

- programs other than Medicare Fee-For-Service (*e.g.*, Medicare Managed Care program)
- the cost report settlement process
- mis-coding Evaluation and Management services, and several others.

Overpayment Determinations Documented and Validated: When RACs identify an overpayment, the rationale will be documented, with references to Medicare rules and policies. Those determinations are then put through a validation process with the RAC Validation Contractor.

Understanding the RAC Program: Identifying and Collecting *Overpayments*

RACs Will Seek to Collect Overpayments: Once identified and validated, the RAC will seek to correct the overpayment.

Notice / Demand: Part A providers will receive a "written notification." Part B providers will receive a "demand letter."

Full or Partial Denial: The letter will detail whether there is a full or partial denial.

Understanding the RAC Program: Identifying and Collecting *Overpayments*

Reporting: Suspected fraud or quality issues will be reported.

Normal Collection Mechanisms: The overpayment amounts will likely be collected through recoupment vis-à-vis present or future Medicare payments. Other recovery mechanisms will also be available (*e.g.*, twelve month installment plans, referral to United States Treasury for collection, etc.). Collection is a crucial component of the RAC's work because the recovery of overpayments is a prerequisite to the receipt of contingency payments.

Understanding the RAC Program: The Coverage/Coding Reviews

Automated Reviews

Used to Identify Clear Errors: Automated reviews are allowed in circumstances when it is "certain" that payment for services is improper. Example:

Example: An Oncology Practice performs a particular medical service over a 7 month period to patients with a particular medical condition. The Oncology Practice was unaware that one-year ago, a new National Coverage Determination ("NCD") was published with respect to such treatments. The NCD affirmatively states that the medical services provided by the Oncology Practice are never reasonable and necessary for that condition. Because it is "certain" that Medicare's payment for those medical services is improper, the RAC in can utilize data mining techniques to discover that type of billing error.

Understanding the RAC Program: The Coverage/Coding Reviews

Automated Reviews

Not Used if Claim is Potentially Payable: Automated reviews are not used if there is any chance that a claim is payable by Medicare. In those scenarios, RACs that wish to engage in a review of reimbursed services must instead perform a complex medical review. (Example: NCD says a medical service is "rarely" necessary for a particular condition, so reimbursement is theoretically possible).

Understanding the RAC Program: The Coverage/Coding Reviews

Complex Medical Reviews

Used When Improper Payments Likely: Complex Medical Reviews are allowed when there is a "high probability," rather than a certainty, that the services billed are not covered.

Procedure for Medical Records Requests: : Complex medical review involves the inspection of medical records. There are two ways that RACs can request medical records: onsite review or by written request. Keep the following in mind:

- RACs are sometimes required to **pay** for obtaining medical records;

Understanding the RAC Program: The Coverage/Coding Reviews

Complex Medical Reviews

- If a provider refuses access to medical records during an onsite review, the RAC is not allowed to make an overpayment determination on that basis. Instead, the RAC must request the records in writing, at which point the provider must respond in **45 days**. At that point, if the provider fails to respond, the RAC can then make an overpayment determination.

- RACs are subject to **medical record request limits**: http://www.cms.hhs.gov/RAC/Downloads/RAC%20Medical%20Record%20Request%20Limits.pdf

- To ease the burden of such requests, CMS permits providers to securely transmit records via **electronic means** (*e.g.*, CDs)

Understanding the RAC Program: Other Structural Nuances

Extrapolation: RACs may extrapolate their findings to determine the overpayment amount.

Referrals / Tips: RACs may receive and consider referrals or tips regarding potential overpayments, but they are under no obligation to conduct a review.

Understanding the RAC Program: Other Structural Nuances

RAC Data Warehouse: To prevent duplicate reviews, RACs will submit selected provider and claim data to a web-based application called the RAC Data Warehouse. If a claim has already been reviewed, it will be deemed "excluded." If the provider or claim is part of an ongoing fraud investigation, that provider or claim will be deemed "suppressed." Before conducting a review, RACs will use the RAC Data Warehouse to ensure the target of the review is not excluded or suppressed.

RACs Lack Settlement Authority: RACs will not have any authority to compromise or settle overpayment debts. Providers are still permitted to make settlement offers, but the RACs will simply forward those offers to CMS, along with a recommendation. CMS will then determine whether the offered settlement is in its best interest.

Understanding the RAC Program: A Potential Cause for Concern

RAC Clinical Judgments

RACs must follow Medicare policies. RACs will also be staffed by a physician medical director and certified coders.

The problem is that, according to CMS, RACs will have the authority to use medical literature and clinical judgment to deny claims in the absence of a national or local policy.

Providers should be prepared to exercise their Medicare appeal rights in order to challenge such judgments when appropriate.

Engaging the Medicare Appeals Process

The 5-Step Appeals Process

Step 1: Redetermination (*Fiscal Intermediary*, *Carrier, MAC*)

Step 2: Reconsideration (*Qualified Independent Contractor*)

Step 3: Administrative Judge Hearing (*Administrative Law Judge*)

Step 4: Administrative Council Review (*Medicare Appeals Council*)

Step 5: Judicial Review (*U.S. Federal District Court*)

Engaging the Medicare Appeals Process

The 5-Step Appeals Process

Note: It appears providers will also have access to a "rebuttal process" that will precede the appeals process. Providers may be able to respond directly to a RAC within 15 days of an overpayment determination. This may be an excellent tool for providers that somehow failed to respond to a RAC letter requesting medical records. The rebuttal process does not postpone the recoupment or appeal deadlines.

Engaging the Medicare Appeals Process

Step 1: Redetermination

Timing: 30 days avoids recoupment | 120 days is the final deadline to submit request for redetermination, absent good cause

Interest: Begins to accrue 41 days from the overpayment letter

Request Filed With: Fiscal Intermediary or Carrier, and soon, MACs

Content: HIC Claim Number; Services and Dates of Service at Issue; Reasons for Disagreement with Overpayment Determination; Evidentiary Support (Medical Necessity Claim)

Engaging the Medicare Appeals Process

Step 1: Redetermination

Redetermination Conducted By New Person : Someone new at the FI or Carrier or MAC will conduct the redetermination by reviewing the initial findings and evidence, as well as new and additional evidence presented by the provider

Timing of Decision: 60 days

Nature of the Decision: Favorable, Partially Favorable, Unfavorable

Engaging the Medicare Appeals Process

Step 2: Reconsideration

Timing:	60 days avoids recoupment | 180 days from Partially Favorable or Unfavorable Redetermination
Filed With:	*Qualified Independent Contractor*
Content:	All evidence relevant to issues in dispute, the disagreement with the result of the initial overpayment determination, and redetermination explained

Engaging the Medicare Appeals Process

Step 2: Reconsideration

Medical Necessity Issues: If the medical necessity of an item or service is at issue, reconsideration will involve a panel of physicians or other health care professionals that make decisions based on clinical experience, medical records, and other scientific evidence

Physician Services Issue: If the medical necessity of physician services is at issue, a physician must be involved in the reconsideration, but that physician does not have to be in the same specialty

Engaging the Medicare Appeals Process

Step 2: Reconsideration

Timing of Decision:	60 days
Nature of the Decision:	Written notice detailing a reversal or affirmance of the initial determination in whole or in part

Engaging the Medicare Appeals Process

Step 3: Administrative Law Judge Appeal

Timing: 60 days from QIC decision

Amount In Controversy Minimum: at least $130.00

New Evidence: No new evidence is introduced at this level of appeal

Hearing Election: A hearing can be requested or waived so that an ALJ can make a decision based on the paper record

Location: There are four HHS offices that handle such hearings, but the use of telephone or video conferencing is more likely

Engaging the Medicare Appeals Process

Step 3: Administrative Law Judge Appeal

CMS / Contractors: These organizations can decide to participate in a hearing

Notice of Hearing: Sent 20 days before it is scheduled to occur

Decision in 90 Days: The ALJ will issue a written decision with findings of fact, conclusions of law, and reasoning for the decision

Engaging the Medicare Appeals Process

Step 4: Medicare Appeals Council

Timing: Appeal filed within 60 days of ALJ decision

Decision to Review: The Council will deny or grant a request for review

The Review: The Council will either issue a decision itself or send the case back to the ALJ for further action

Engaging the Medicare Appeals Process

Step 4: Medicare Appeals Council

Standard for Review:

- abuse of discretion
- error of law
- ALJ findings or conclusions are not supported by substantial evidence
- There is a policy or procedural issues affecting the public interest
- New and material evidence

Engaging the Medicare Appeals Process

Step 5: Review by Federal U.S. District Court

Timing: 60 days from MAC decision

Amount-In-Controversy Minimum: $1,300.00 (1/1/2011)

Audit Defenses

- Provider Without Fault
- Waiver of Liability
- Treating Physician's Rule
- Challenges to Statistics
- Reopening Regulations

Audit Defenses – Provider Without Fault

- Section 1870 of the Social Security Act
- Once an overpayment is identified, payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services.

Audit Defenses – Waiver of Liability

- Section 1879(a) of the Social Security Act
- Under waiver of liability, even if a service is determined to be not reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

Audit Defenses – Treating Physician Rule

- Treating Physician Rule
  - The treating physician rule, as adopted by some courts, reflects that the treating physician's determination that a service is medically necessary is binding unless contradicted by substantial evidence, and is entitled to some extra weight, even if contradicted by substantial evidence, because the treating physician is inherently more familiar with the patient's medical condition than a retrospective reviewer

Audit Defenses – Provider Without Fault

- CMS Ruling 93-1: With respect to Part A Claims
  - CMS Rule 93-1 states that treating physician opinion is evidence, but not presumptive, so need to make a case specific argument why physician's opinion is the best evidence
    - No similar CMS rulings with respect to Parts B, C, or D
- 42 C.F.R. § 482.30: Conditions of Participation: Utilization Review
- Provider should always argue that the opinion of the treating physician is the best evidence

Audit Defenses – Challenges To Statistics

- Section 935 of the MMS
- The guidelines for conducting statistical extrapolations are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08), Chapter 3 §§ 3.10.1 through 3.10.11.2

Engaging the Medicare Appeals Process

Things To Do:

1. Objectively determine whether the overpayment determination was improper;
2. Assess the current / future reimbursement dollars at risk by performing internal audits and take corrective action when necessary;
3. Ascertain the cost of engaging the appeals process, broken down by stage;

Engaging the Medicare Appeals Process

Things To Do:

4. Investigate and find whether evidentiary support exists;
5. Research whether any primary or secondary sources of reimbursement law or Medicare reimbursement policy help or harm your position (*e.g.*, regulations, National Coverage Determinations, Local Coverage Determinations, articles, etc.); and,
6. Determine whether any fraud or other illegal conduct occurred.

Engaging the Medicare Appeals Process

Things to Avoid:

1. Engaging the appeals process when its more intelligent and cheaper to pay immediately and avoid interest;
2. Missing time deadlines;
3. Providing little or no evidentiary support;
4. Providing limited analysis; and,
5. Failing to fix identified problems going forward.

Medicaid RACs Program

Establishment of program.

(a) The Medicaid Recovery Audit Contractor program (Medicaid RAC program) is established as a measure for States to promote the integrity of the Medicaid program. Effective date is January 1, 2012.

The goal is to reduce Medicaid waste and fraud by $2.1 Billion over five years.

(b) States must enter into contracts with one or more eligible Medicaid RACs.

Medicaid RACs Program

Definitions

Medicaid RAC program means a recovery audit contractor program administered by a State to identify overpayments and underpayments and recoup overpayments.

Medicare RAC program means a recovery audit contractor program administered by CMS to identify payments and overpayments and recoup overpayments.

Medicaid RACs Program

Activities to be conducted by Medicaid RACs and States

(a) Medicaid RACs will review claims submitted by providers of items and services or other individuals furnishing items and services for which payment has been made.

1) States may exclude Medicaid managed care claims from review by Medicaid RACs.
2) States may coordinate with Medicaid RACs regarding the recoupment of overpayments.
3) States must coordinate the recovery audit efforts of their RACs with other auditing entities.
4) State must make referrals of suspected fraud and/or abuse to the MFCU or other appropriate law enforcement agency.
5) States must set limits on the number and frequency of medical records to be reviewed by the RACs.

Medicaid RACs Program

Eligibility requirements for Medicaid RACs

(a) An entity that wishes to perform the functions of a Medicaid RAC must enter into a contract with a State to carry out any of the activities under the following conditions:

a) The entity must demonstrate to a State that it has the technical capability to carry out the activities.

b) The entity must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing.

c) The entity must hire certified coders.

d) The entity must work with the State to develop an education and outreach program.

e) The entity must provide minimum customer service measures.

Medicaid RACs Program

Eligibility requirements for Medicaid RACs

f) The entity must not review claims that are older than 3 years from the date of the claim.

g) The entity should not audit claims that have already been audited or that are currently being audited by another entity.

h) The entity must refer suspected cases of fraud and/or abuse to the State in a timely manner.

i) The entity meets other requirements as the State may require.

Medicaid RACs Program

Payments to RACs

a) General. Fees paid to RACs must be made only from amounts recovered.

b) Overpayments. States must determine the contingency fee rate to be paid to Medicaid RACs.

1. The contingency fees paid to Medicaid RACs must be based on a percentage of the overpayment recovered.
2. States must determine at what stage in the Medicaid RAC audit process Medicaid RACs will receive contingency fee payments.
3. If a provider appeals a Medicaid RAC overpayment determination and the determination is reversed, at any level, then the Medicaid RAC must return the contingency fees.
4. The contingency fee may not exceed that of the highest Medicare RAC, unless the State submits, and CMS approves, a waiver of the specified maximum rate.

Medicaid RACs Program

Payments to RACs

c) Underpayments.

1. States must determine the fee paid to a Medicaid RAC to identify underpayments.
2. States must adequately incentivize the detection of underpayments.
3. States must notify providers of underpayments that are identified by the RACs.

Medicaid RACs Program

Medicaid RAC provider appeals

States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination.