How to Successfully Appeal a RAC Audit

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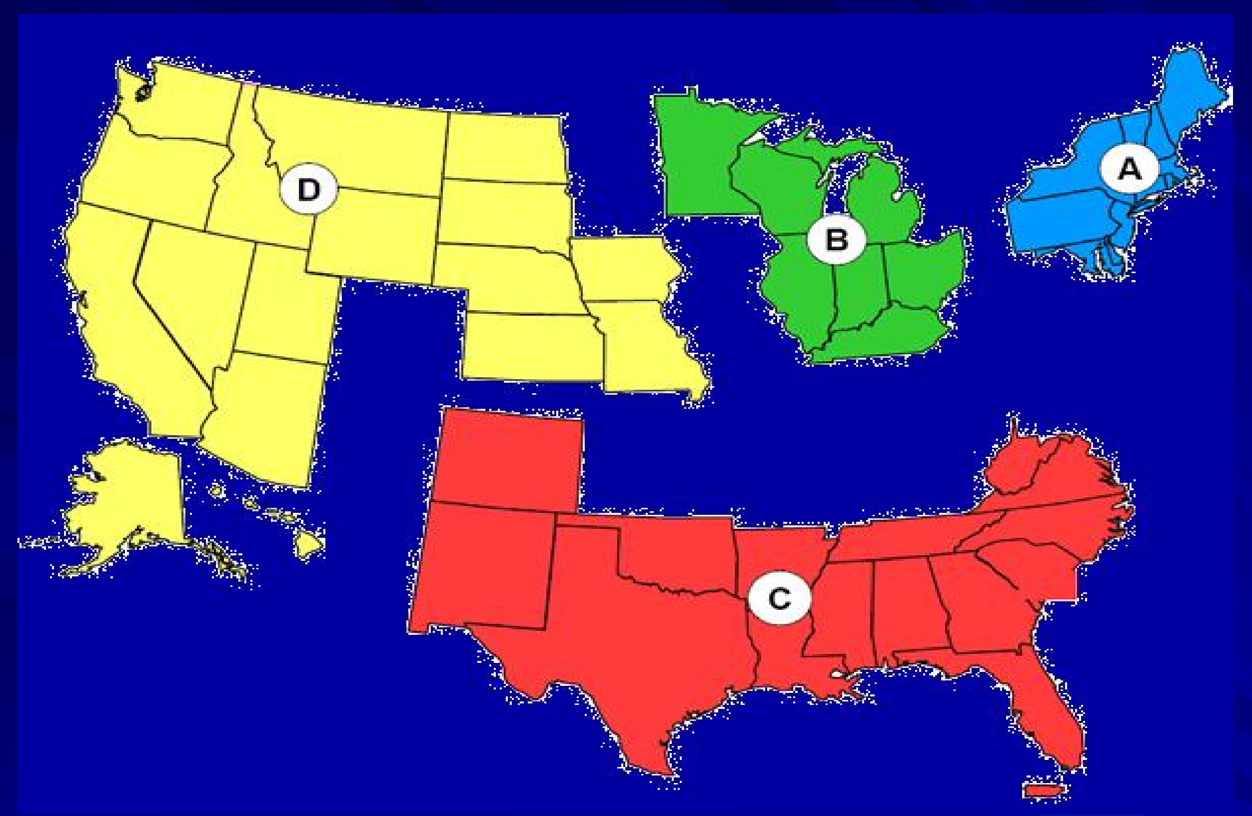
General Background

- "RAC"- Recovery Audit Contractor
- The Medicare Prescription Drug, Improvement, and Modernization Act (2003)
- The RAC Demonstration Program:
  - California, Florida and New York
  - Extended to Massachusetts, South Carolina and Arizona
  - $992.7 Million in Overpayments

General Background Cont'd…



- Region A – Diversified Collection Services ("DCS") Healthcare
- Region B – CGI Federal
- Region C – Connolly Healthcare
- Region D – HealthDataInsights

Who and What are the RACs Auditing?

- Hospital claims accounted for 95% of Overpayments collected during the Demonstration

- The Basis for Overpayment Determinations:
  - 40% Not Medically Necessary
  - 35% Incorrect Coding
  - 17% Clerical Errors (i.e., Duplicate Claims)
  - 8% Insufficient Documentation

How to Prepare for a RAC Audit

- Four Key Measures
  - Documentation
  - Stay Informed
  - Monitor Activities and Identify Risks
  - Utilize a Physician Advisor (e.g., Accretive Health, Inc.)

Documentation

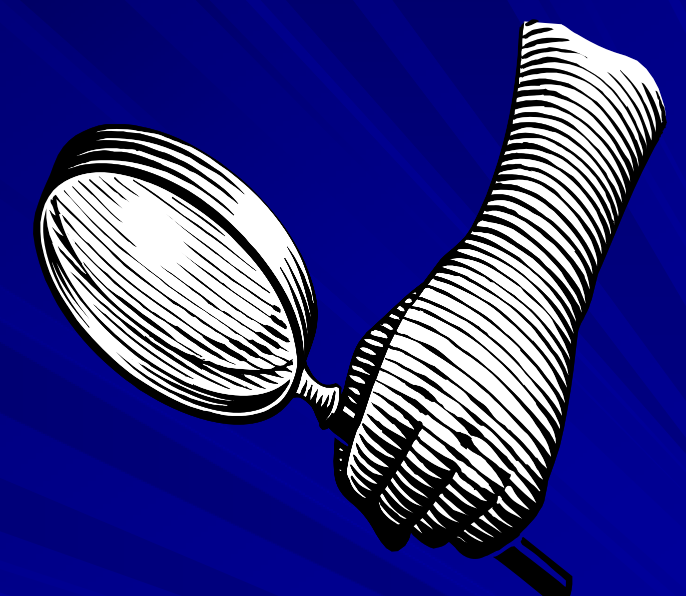
- Establish and Maintain Sufficient Medical Records
- Medical Documentation helps *Prevent* RAC claim denials and *Support* the Challenge of a denial through the Appeals Process

Stay Informed

- The CMS Website
- The RAC websites
- Monitor for Updates

Monitor Activities and Identify Risks

- Don’t Repeat Mistakes
- Identify Common Issues
- Repay Indentified Overpayments



The Role of A Physician Advisor (e.g., Accretive Health, Inc.)

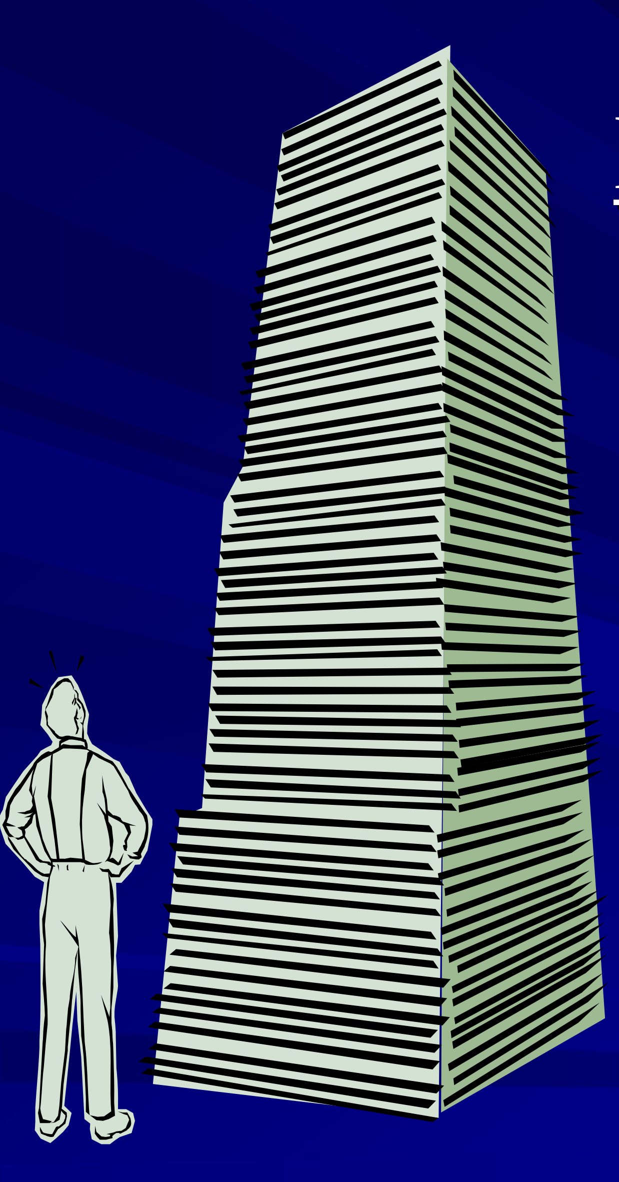
- Provide Classification Status
- Educate the Staff
- Know the Appeals Process
- Write Appeal Letters:
  - Include Proper Documentation
  - Refer to CMS Policy
  - Cite to Medical Literature
  - Provide Expert Opinions

The Review Process

- Two Types of Post Payment Review
  - Automated Review:
    - Computer Algorithm
    - No Record Request
    - Demand Letter only if there is an Overpayment
  - Complex Review:
    - Request for Medical Records (w/in 45 days)
    - Review Results Letter
    - Demand Letter if there is Overpayment

The Five Stages of The Formal Appeal Process

1. Request for Redetermination
2. Request for Reconsideration
3. Administrative Law Judge (“ALJ”) Hearing
4. Medicare Appeals Council (the “Council”) Review
5. Judicial Review



Request for Redetermination

- File within 120 days of Receipt of the Demand Letter
- Explain why the Initial Determination was Wrong
- Include any Supporting Evidence

Request for Reconsideration

- File with the Qualified Independent Contractor ("QIC") within 180 days of the Redetermination Decision
- Explain why the Initial Determination and Redetermination were wrong
- Ensure that all evidence is made part of the record at this time

Administrative Law Judge Hearing

- The Amount in Controversy must exceed $130
- File with the ALJ within 60 days of receiving the Notice of Reconsideration
- Specify the Reason for the Appeal
- The ALJ conducts a *De Novo* Review

Medicare Appeals Council Review

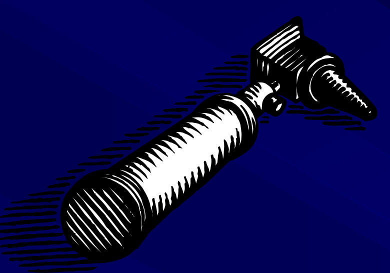
- File with the Council within 60 days of Receipt of the ALJ's Decision
- State why the ALJ's Decision is wrong and provide Facts and Law Supporting your Position
- The Council conducts a *De Novo* Review

Judicial Review

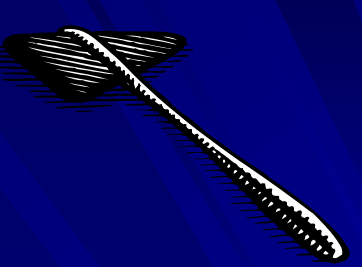
- The Amount in Controversy must exceed $1,260
- File in Federal Court within 60 days of receiving the Council's Decision
- Name the Secretary of HHS as the Defendant

Why Appeal?

- According to the CMS' June 2010 Report, *The Medical Recovery Audit Contract (RAC) Program: Update to the Evaluation of the 3-Year Demonstration,* the success rate for providers challenging RAC determinations through March 9, 2010 was approximately 64%



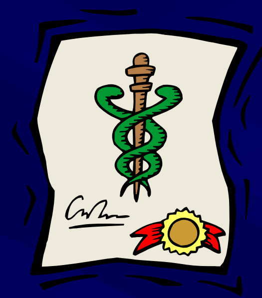
Types of Appeals



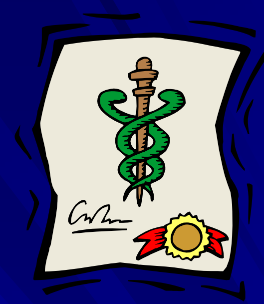
- Medical Necessity:
  - 40% of claims were found to be Medically Unnecessary
  - CMS has not Authorized RACs to Conduct Medical Necessity Reviews in the Permanent Phase
  - RACs are Expected to Begin Medical Necessity Reviews later this Summer
- Strategy for Appeals:
  - Retain and Produce Medical Records that show Beneficiary's Condition at Presentation
  - Obtain a Second Opinion from another Physician (i.e., a Physician Advisor)

Types of Appeals Cont'd…

- Extrapolations:
  - Not used in the Demonstration Phase
  - RACs are Permitted to Estimate an Overpayment through use of an Identified Error Rate
  - The Methodology must be Approved by CMS prior to the Audit
  - Strategy for Appeals
    - The Provider may Appeal Individual Claims
    - The Provider may Appeal the Method of Extrapolation



Recent Law



- In the Case of *O'Connor Hospital* (Feb. 2010)
  - Medicare paid the Provider's claim for inpatient hospitalization services (Medicare Part A)
  - The RAC found the services were not Medically Necessary
  - On Appeal, although the Administrative Law Judge ("ALJ") found that the services were not reasonable and necessary, the ALJ found that the "observation and the underlying care were warranted" and therefore required payment under Medicare Part B (outpatient care expenses)
  - Feb. 1, 2010, Council affirmed ALJ's decision and required the Contractor to work with the Provider to arrange for Payment under Medicare Part B

Recent Law Cont'd…

- *Palomar Medical Center v. Sebelius* (Cal. March 2009)
  - RAC Reopened a Claim and denied coverage more than One Year after Payment by Medicare
  - The Provider filed an appeal asserting lack of "good cause" for the reopening
  - ALJ held that the RAC lacked "good cause"
  - The Council reversed the ALJ's decision finding the RAC's decision to reopen final
  - The Federal Magistrate issued a Report Recommending that the Court enter an Order finding the RAC's decision final
  - The Provider recently filed a Motion to Stay Proceedings in this matter until the resolution of a related case arising from a Freedom of Information Act request issued by the Provider

Patient Protection and Affordable Care Act

- Signed into law in March 2010
- Mandates the Expansion of the RAC Program to Medicaid for all States
  - States must enter by December 31, 2010
- Mandates the Expansion of the RAC Program into Medicare Parts C (Medicare Advantage) and D (Prescription Drugs)

Q & A