

Recovery Audit Contractors



As if physicians and health care professionals did not already have enough to worry about, now there is a new threat! Much like the Swine Flu, RACs cause fever, muscle weakness and sore throat from all of the screaming done when you received one of two types of letters from these “Bounty Hunters.”

If you have turned to CMS for answers, you most likely found yourself scratching your head after one of their conference calls that provided almost nothing in the way of guidance or concrete answers. With that in mind I felt compelled to share with you what you can expect WHEN you go through the process. How is it that I can provide you with insight as to what you can expect as a consultant when CMS who is responsible for the program can't or does not seem to want to?

I have gone through the appeal process now with multiple clients actually taking appeals as high as the Medicare Appeals Counsel where they actually upheld a wholly favorable decision rendered at the Administrative Law Judge level.

I must be honest with you, this is not an easy process and the RACs often do not play fair but the good news is, if you are proactive, and you take the steps necessary to cover your assets, you can actually walk away unscathed.

Let's look at some of the facts:

1. Type of Notifications:

a. Automated – demand for repayment

- i. ie: CPT 36430 only one unit per day allowed

- ii. (30 days to dispute / 41 days to refund)
- iii. Data crunching combined with a written Medicare policy, article or sanctioned coding guideline.
- iv. This also includes duplicate claims.
- v. Note: If the RAC identifies a “clinically unbelievable” claim (the codes on the claim cannot be accurate but there is no written policy), RAC may seek CMS approval for an automated review.

b. Complex – requires medical record review

- i. ie: DRG assignment / sequencing
- ii. (60 days to review)
- iii. Medical records are involved in the review, high probability (but not certainty) that the service is not covered.
- iv. The RAC will request medical records from the provider to further review the claim. The RAC would then make a determination as to whether payment of the claim was correct, an overpayment, or an underpayment.
- v. This is similar to current processes by carriers.
 - Both come by mail,
 - Both are uncovered by data mining.

2. Responsibility of RACs

- i. Look at claims at least one year old
- ii. Identify under-and over payments
- iii. Paid on a contingency basis–On overpayments identified

- iv. May not look at pure over coding of E&M services –at least not now!
- v. May look for medical necessity & global surgery package, CCI edits, multiple surgery rules.

3. The Recovery Audit Contractors:

- i. Diversified Collection Services, Inc. of Livermore, CA: Region A (ME, NH, VT, MA, RI, NY).
- ii. CGI Technologies and Solutions, Inc. of Fairfax, VA: Region B (MI, IN, MN).
- iii. Connolly Consulting Associates, Inc., of Wilton, CT: Region C (SC, FL, CO, NM).
- iv. HealthDataInsights, Inc. of Las Vegas, NV: Region D (MT, WY, ND, SD, UT, AZ).

4. RAC Contingency Fees:

- i. Region A – 12.45%
- ii. Region B – 12.50%
- iii. Region C – 9%
- iv. Region D – 9.49%

There are many differences between the demonstration project and the permanent program. As an example, RACs are required to employ a full-time medical director to assist in the review of claims. The problem is, in one instance I found the medical director for the RAC was the same medical director for the carrier in the region. The big problem with this in my mind is, a conflict of interest. This is the same person who helps to create the policies for the carrier, which does everything they can to deny your claims. Another change is the “Look-Back” period. This has been reduced from 4-yrs to 3-yrs which, is a good thing. Additionally, the maximum look-back date is 10/1/07. Under the permanent program there are mandatory internal audits required. There is supposed to be a RAC claim status web page established by January 2010. There is a mandatory external validation process to ensure the program is operating as required. And finally, RACs are required to return contingency fees, if an overpayment determination is overturned at any level in the appeals process.

It is crucial to keep in mind that RACs are not intended to replace other review efforts by:

Fiscal Intermediaries, Part B and DME Carriers, Program Safeguard Contractors (PSC), Benefit Integrity Support Centers (BISC) Quality Improvement Organizations (QIO) or the Office of Inspector General (OIG). These threats all remain in place. However, RACs cannot audit claims for: Services not included in Medicare FFS; Cost report settlement process; A random selection of claims; Claims with “special processing numbers” (such as demonstration projects); or Claims in a prepayment review. RACs also cannot audit claims that have been audited by “Affiliated Contractors (AC),” which means DME, MAC, Part B carrier, QIO, or FI. Also, RACs will not audit services under investigated

as part of potential fraud cases by Benefit Integrity Program Safeguard Contractors or law enforcement agency (OIG, DOJ). CMS is requiring a validation process to ensure no duplicate audit of claims.

One of the questions I get often is, what specifically will a RAC look at in a physician practice... There are many answers to this question and it varies by specialty. What you need to consider when trying to identify the services that may be looked at in your practice is, first what are the high dollar services you provide and second, is what are the highest volume services you provide? A few examples of services that might be looked at in a physician practice are:

- Joint injections.
- Lesion destruction and excisions.
- Laceration Repair.
- E/M services might be identified and audited through a closer examination of procedure codes (e.g. a charge for a high level E/M code for pre-op H&P just a few days before the procedure would be disqualified).

What about E/M services? Generally these are not subject to a RAC audit.

Exceptions:

- E/M services not reasonable and necessary.
- Violations of Medicare global surgical billing and payment rules.

Believe it or not, RACs may obtain medical records by going onsite to your location to view or copy the records. Don't worry though, if you refuse to allow access, the RAC cannot make an overpayment determination based upon lack of access, but must instead request the records in writing. Providers will have 45 days to respond, which means you must provide the records within 45 days, or request an extension within 45 days. If you do not respond, the RAC must attempt to contact you one more time. If you still do not respond, the RAC may find a claim to be an overpayment. Don't procrastinate, if you are not sure what steps you need to take contact the RAC immediately upon receiving notice. If you do not get the answers you are seeking contact the carrier or a qualified consultant or attorney to work with you on getting your issue resolved.

There are four steps in the process:

1. Receiving RAC Request. This is where you will receive a letter from your RAC. The letter is typically sent to the physician, administrator, or other individual you have designated as the “RAC Liaison.” Don't panic, but don't take this lightly – a Medicare audit is similar to one by the IRS: You are guilty until proven innocent. The burden of proof is on your shoulders.

2. Responding to RAC Request:

- a. Initial questions when preparing response.
- i. Are there any previously evaluated claims?
- ii. What amount of detail should you submit?

b. Begin preparation:

- i. Gather and copy all appropriate documents requested by the RAC.
- ii. Review all information regarding the information being audited.
- iii. Make sure if there were referrals from other providers you have a record of such requests.
- iv. Where else besides the patient chart would information be maintained?
- v. Are there records at the hospital you may need or from other providers involved in the patient's care?

c. Don't forget to ask for an extension if needed.

3. Notification of Outcome: Keep in mind that RACs will only provide results of an automated review if there is an overpayment. If your practice has gone through a complex review, the RAC has only 60 days to complete audit after receiving records.

- a. RAC letter should contain:
- b. Audit results, identifying overpayments and under payments.
- c. Coverage, coding or payment policy or article violated.
- d. Rights of appeal.
- e. Contact information.
- f. Payment refund procedures.

4. Appeal Processes: The Medicare Appeals process will remain the same for physicians under Part B and Part A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the PPS. In the current appeals process, the first level appeal will go to the Quality Improvement Organization (QIO); however, the RAC appeals will go to the FI that processed the claim. Below is the appeals process:

- a. First level – redetermination. This is a written request within 120 days to your carrier or FI (not the RAC). The carrier/FI has 60 days to respond.
- b. Second level – reconsideration. This is a written request on a standard CMS form within 180 days to your Qualified Independent Contractor. The QIC has 60 days to respond.
- c. Third level – ALJ hearing. This is an in-person, telephone, or videoconference hearing. You must request the hearing 60 days after the reconsideration. The amount in controversy must be \$120.

In general, RAC determinations may be appealed in the same manner as any Medicare appeal –

- First Level – Redetermination by the Medicare contractor

- Second Level – Reconsideration by the Qualified Independent Contractor (QIC)
- Third Level – Hearing by an Administrative Law Judge (ALJ).

Except:

The RAC initial determination is appealed to the Medicare contractor that initially paid the claim; not the RAC that made the initial determination. Providers may informally dispute claims to the RAC prior to appealing. If the RAC agrees with the provider, the RAC will not issue a payment reduction to the Medicare contractor. If the RAC disagrees with the provider, the RAC notifies the contractor of the payment adjustment.

So now that we have talked about the facts of the program, let's talk about some tips to assist you with being successful through the process:

- Document all communication between you and RACs, carriers/FI, ALJ, etc.
- Research supporting documentation to help your case.
- Review appeal documentation to ensure it is complete, accurate and convincing.
- Be on time!
- Designate an individual to serve as the RAC liaison.
 - Compliance officer
 - HIM director
 - Administrator or Office manager

Learn what may be a target of the RAC:

- National areas of focus and type of review:
 - Debridement (complex)
 - Respiratory Failure (complex)
 - Medical back pain (complex)
 - Transfusion codes (automated)
 - Speech therapy (automated)
 - Neulasta (chemotherapy) (complex)
 - Conduct your own internal data mining.
 - High volume services

Document and track RAC audit requests as well as your responses.

- Perhaps use a system to organize the requests by type of issue and financial impact.
- Verify that the claim is open for RAC to review.
- Do not assume RAC database is accurate.
 - If you conclude line item on claim has already been reviewed, notify RAC, FI, QIO, etc.
- Review each request carefully.
- Use a qualified individual to perform an internal audit.
- Prioritize review of claims by time remaining to respond; financial impact; and volume of claims with common issues.

The goal is to avoid any technical denials. Keep in mind that if volume of requests / demands is determined to be excessively burdensome, formally request extension to RAC. A couple of items to keep in mind are: is the RAC's determination of overpayment correct? Make sure that you understand the specific rules or policies that are included in the determination letter. Second, Do not blindly accept the RAC's interpretation of rules/ guidelines. Look to see if policy or rules has changed over time. Then, ask yourself the most important question; is an appeal warranted? Consider appealing medical necessity denials. Why? Medical necessity is inherently subjective. LCDs have not been subjected to serious clinical scrutiny and change often. Identify underpayments on both RAC targeted claims and others. Request waiver of timely filing deadlines for identified underpayments. When an overpayment is correct, determine and implement corrective action to avoid repeated scrutiny. If desired, ask to pay on an installment plan. Ask for partial payment whenever possible. Determine if others (patients, payers) will pay denied claim.

My Final Thoughts:

Continue to be proactive in your coding and billing. Make sure

to submit corrected claims if it is appropriate. Take immediate action when RAC letters are received and provide education to all individuals based on RAC findings (and document education attendance.) Evaluate the need for external assistance and guidance to help navigate your internal RAC team through the process. If you disagree with the RAC determination, file an appeal before the 120-day deadline. Keep track of denied claims and correcting previous errors. Determine what corrective actions need to be taken to ensure compliance with Medicare's requirements and to avoid submitting incorrect claims in the future. 

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