

# *What Every CEO Should Know About Medicare's Recovery Audit Contractor Program*

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**U**nder the Affordable Care Act, President Obama expressed his support for the use of "high-tech bounty hunters" to help fight healthcare fraud in the Medicare and Medicaid programs (US Government 2010). President Obama was referring to the recovery audit contractors (RACs) employed by Medicare, tasked to identify and correct improper Medicare payments. Contractors are highly incentivized to identify payment errors as a result of their contingency-based compensation arrangements. RACs' contingency rates range from 9 to 12.5 percent and are based on the principal amount recouped from or refunded to the provider or supplier.

The fiscal landscape in healthcare today is severely overburdened by a litany of varying payment schemes, preadmission certification criterion, and regulatory mandates. In keeping up with these requirements, providers manage the deluge of third-party audits, all simultaneously requesting information (Blue Cross Blue Shield of Massachusetts 2009). The RAC can request up to 10 percent of Medicare discharges, but never more than 300 medical records (in certain cases, up to 500) every 45 days. Keeping abreast of the various cycles of audit and deadlines required to preserve the right of appeal is an arduous task, and while Medicare RACs continue to ramp up, providers prepare for a new wave of Medicaid and insurance company RAC audits.

The RAC audit program began as a demonstration project under the Medicare Modernization Act of 2003 (MMA) (42 CFR §1395dd 2003). The intent of the project charged the RACs with identification of provider underpayments and overpayments due to payment errors (CMS 2004). RAC audits began in 2005, focused on overpayments, in the three states with the highest Medicare expenditures: California, Florida, and New York. The program was expanded in 2007 to Massachusetts, South Carolina, and Arizona. In June 2010, the Centers for Medicare & Medicaid Services (CMS) reported an astounding \$693.6 million net return from those first six states over a period of three years to Medicare trust funds, with 85 percent from acute care hospitals (CMS 2010). During the demonstration project, providers appealed only 12.7 percent of denials, of which 64.4 percent were decided in the providers' favor (CMS 2008). On the cusp of what was considered a huge success by CMS, the project became permanent under section 302 of the Federal Tax Relief and Healthcare Act of 2006.

Under Section 935 of the MMA and the RAC Statement of Work (CMS 2004, 6), RACs must use proprietary data analysis techniques to perform a targeted review to predict the claims likely to contain overpayments. RACs perform two types of claim reviews: automated and complex. An automated review is a review of claims data only. When data are extrapolated from a small number of claims, such as with duplicate services or once-in-a-lifetime procedures, into a much larger universe of claims, the projected results can be staggering. Complex reviews include scrutinizing the medical record to uncover medically unnecessary services and DRG miscoding.

Prevention is the axiom we all know and respect, yet the harsh reality is that while the RACs collect contingency *payments* for their success, providers need to *plan* to counter. Providers who strive for coding precision for clinical and payment accuracy on the front end should construct appeal plans as a must to mitigate overall impact on the back end.

Much national debate is ongoing in anticipation of the Medicaid RACs. While CMS has taken a top-down approach to the administration of the Medicare RACs, the states will maintain control over the rollout of the Medicaid RACs. Power over healthcare as a whole is presently shifting to the federal level, obscuring the degree of autonomy the states will truly retain with administration of Medicaid. Yet uncertainty remains. Healthcare reform has received criticism in terms of the federal power and individual rights as to health insurance, an issue that we believe is headed for the Supreme Court. The *New York Times* (Pear 2011) reported that the House Republicans said that they would pass discrete bills to achieve some of the same goals, but with more restraint in the use of federal power. Federal power over healthcare today stretches from clinical documentation and privacy to payment of claims and retrospective audit, traveling far beyond state borders. However, because the states have historically maintained administration of the Medicaid program, the Medicaid RAC appeal procedure will be up to the discretion of each state. In terms of the struggle over the states' desire to retain control of Medicaid, a lack of uniform appeals procedures between the Medicare and Medicaid RACs will be problematic for providers. A good analogy here is the difference between filing annual federal tax returns and state tax returns. Every state is different and filing in each state requires unique work and effort.

Likewise, providers must keep track of multiple audit cycles each with individual time lines or else risk technical denials in order to preserve the right of appeal. For example, failure to supply a medical record within the required time frame results in a technical denial. Once this occurs without good cause, the provider appeal rights under the RAC are permanently waived. Payment denials can be generalized into three categories:

1. Provider agrees with the RAC or case value is low; no appeal
2. Provider disagrees with the RAC and case has value; will appeal
3. Provider and RAC disagree on interpretation of regulation; may appeal

The ICD-9-CM Official Guidelines for Coding and Reporting are the framework of rules that providers use to assign the proper codes to each claim for billing. In

some instances, coding rules are not clear. These gray areas in the rules can sometimes lead to code assignment based on one interpretation of the rules versus another, which in turn can result in payment denial. Coders are charged with the delicate balance of choosing between two legitimate codes in order to collect the most appropriate reimbursement. When the RAC disagrees with the code assignment, a Review Results Letter is generated. The letter provides notice to the provider of the basis to the denial, which the provider can then use to determine whether an appeal is indicated. Evaluation of cases for appeal requires a two-pronged approach:

1. Whether the documentation justifies the code assignment(s)
2. If the documentation does not justify the assignment, whether the case should be appealed on legal grounds

Appeal statistics show that hospitals rarely appeal their denials at all (Pear 2011), and of the cases that are not appealed, in many instances that lack of appeal is because of a failure to evaluate beyond the first prong. Failure to evaluate each case under the second prong is a mistake providers routinely make. When the coding staff agrees with the RAC auditor, the provider should always evaluate the case again to determine whether there are any legal grounds for appeal.

Other issues to take into consideration before appeal include the option to re-bill (CMS 2011a) for Part B services and whether the provider would benefit from the MMA limitation on recoupment (CMS 2011b), which allows the provider to avoid refunding the overpayment during appeal. The right to rebill for Part B services exists only when the ordinary filing limits have not expired.

Several theories can be invoked in order to lodge a valid appeal, such as waiver of liability (42 CFR §405 1996), provider without fault (Social Security Act §1879(a)), due process (Montilla v. INS 1991, Clemente 2010), treating physician rule (20 CFR §404.1527(d)(2)) 2006), and the Medicare act's prohibition against federal interference (42 USC §1395 2010). Appeals can be time-consuming and complicated, but the rate of reversal in the demonstration project suggests appeals are worth the effort.

Expert testimony, along with a concise and organized legal brief asserting the background of facts and legal argument in support of each claim, places the provider in the best possible position to effectively advocate the merits of a disputed claim. The appeal levels are as follows:

- **Level 1:** The provider must appeal for redetermination to the Medicare Administrative Contractor within 120 days of the RAC's initial decision. If the appeal is made within 30 days, there is no automatic recoupment of funds. Otherwise, funds are taken back on day 41.
- **Level 2:** Reconsideration is submitted to the Qualified Independent Contractor (QIC) within 180 days of the redetermination or 60 days to avoid recoupment on day 61. The regulations require providers and suppliers to *present all evidence*, allegations of fact, or law related to the issues in dispute at this stage.

- **Level 3:** Cases may be bundled in this stage for efficiency. The Administrative Law Judge (ALJ) hearing can be requested if the amount in controversy is at least \$130 and requests for an ALJ hearing must be received within 60 days of the provider's notice of the reconsideration outcome.
- **Level 4:** Medicare Appeals Council (MAC) request for review of the ALJ's decision may be submitted to the Departmental Appeals Board (DAB)/(MAC) within 60 days of the ALJ decision and meet an amount-in-controversy requirement of \$130. CMS or any CMS contractor can refer a case to the MAC within 60 days on an ALJ decision or dismissal if in their opinion there was an error.
- **Level 5:** U.S. District Court Review may be requested within 60 days of the MAC's decision, and the amount in controversy must be at least \$1,300.

Bear in mind that if the provider fails to prevail on appeal at the QIC, the entire amount plus interest becomes due. This also works in reverse should the provider prevail on appeal (MMA §935 2003).

The best advice: Position your facility to manage results efficiently at an early stage, evaluate each case thoroughly, avoid technical denials at all costs, and preserve the right of appeal. Once Medicaid reviews are in full swing, a well-organized appeal management process will be vital. This is an emerging part of the revenue cycle and should be part of the CEO's dashboard of critical items to monitor.

## REFERENCES

20 CFR §404.1527(d)(2) (2006).

*The treating physician is in the best position to determine the best course of treatment for the patient than the RAC auditor can conclude in hindsight.*

42 CFR §405 (1996).

*Under 42 CFR 405.355(a) and 405.358(a)(b)(2), even if it is found that an inpatient admission was not appropriate, the provider of services or such other person as the case may be did not know and could not reasonably have expected to know that payment would not be made for such items or services.*

42 USC §1395 (2010).

*"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided."*

Blue Cross Blue Shield of Massachusetts. 2009. "Blue Medicare PFFS Medicare Advantage Private Fee-for-Service Plan Terms and Conditions of Payment." Published January 1. [www.bluecrossma.com/staticcontent/medicare\\_pffs/PFFS\\_Terms\\_and\\_Conditions.pdf](http://www.bluecrossma.com/staticcontent/medicare_pffs/PFFS_Terms_and_Conditions.pdf).

Centers for Medicare & Medicaid Services. 2011a. *Medicare Claims Processing Manual*.

*Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. The time limit for rebilling claims is 15 to 27 months from the date of service. These filing rules can be found in Chapter 1, Section 70.*

———. 2011b. "Publication 100-02 Medicare Benefit Policy." <http://www.cms.gov/transmittals/downloads/R141FM.pdf>.

*CMS issued Transmittal 141, which addresses a provider's ability to appeal early under Levels 1 and 2 in order to prevent the automatic recoupment.*

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- . 2004. "Draft SOW and Information Meeting for MMA Section 306." Posted August 4. [www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&\\_cview=1](http://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1).  
*The "appropriate remedy for the refusal of an agency to follow its own regulations may be injunctive relief, reversal of the agency action, or reversal and remand with an order requiring the agency to follow its own procedures."*
- Medicare Modernization Act 42 CFR §1395dd (2003).  
*Section 935 of the Medicare Modernization Act limitation on recoupment must be carefully considered as interest continues to accrue when the provider exercises this option.*
- Montilla v. INS, 926 F.2d at 167 (1991).  
*"The Accardi doctrine is premised on fundamental notions of fair play underlying the concept of due process." The Supreme Court has recognized a rule of federal administrative law which requires agencies to follow their own procedures. "Due process requires that the procedures by which laws are applied must be evenhanded, so that individuals are not subjected to the arbitrary exercise of government power."*
- Social Security Act §1879(a).  
*Under Section 1879(a) of the Social Security Act, Provider deemed to be without fault if the Secretary of Health and Human Services determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if she finds such reduction is consistent with the objectives of this title.*
- Pear, R. 2011. "House Republicans Plan Their Own Health Bills." *New York Times*. Published January 20. [www.nytimes.com/2011/01/21/health/policy/21health.html](http://www.nytimes.com/2011/01/21/health/policy/21health.html).
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