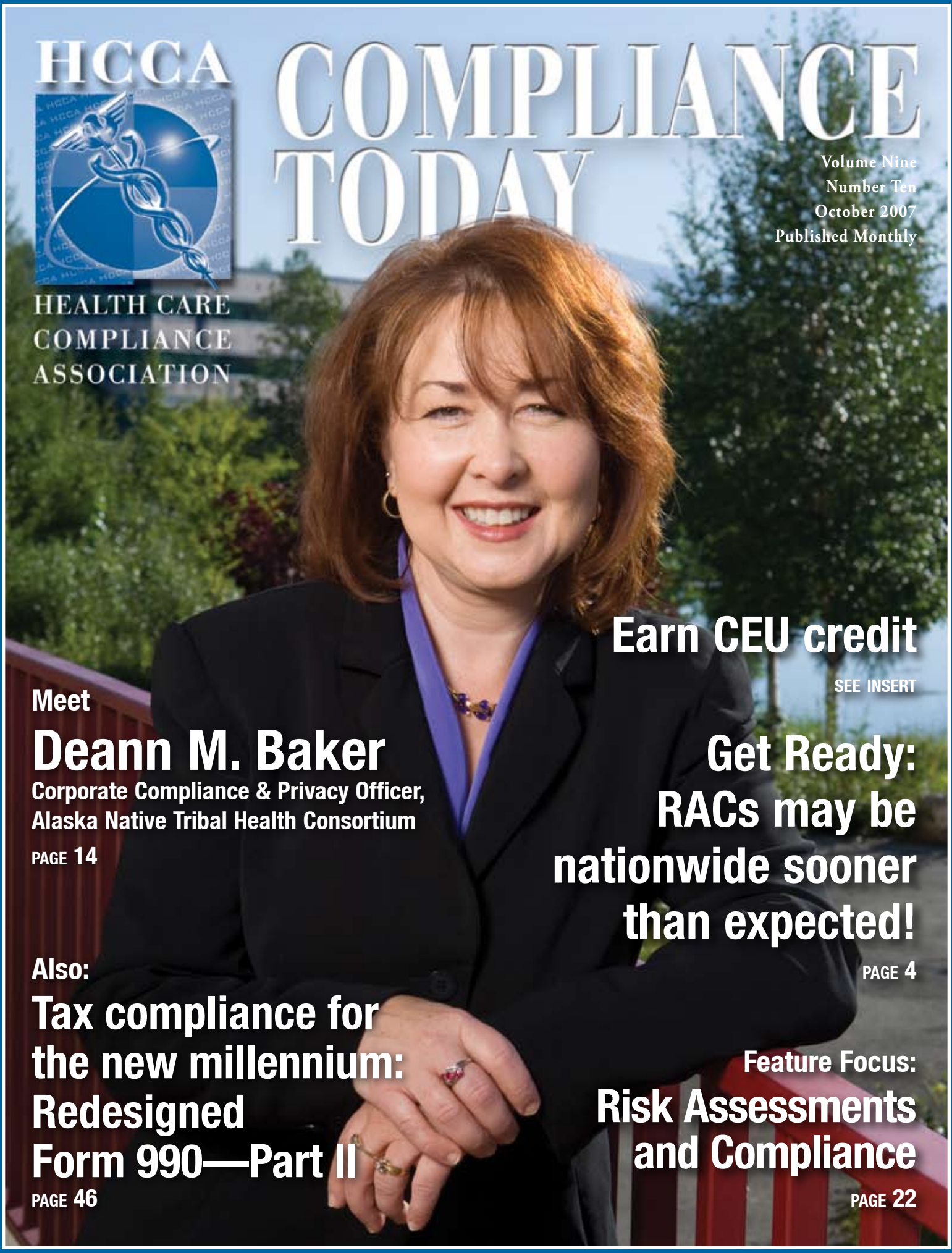
HCCA
HEALTH CARE COMPLIANCE ASSOCIATION
COMPLIANCE TODAY
Volume Nine
Number Ten
October 2007
Published Monthly
Earn CEU credit
SEE INSERT
Meet
Deann M. Baker
Corporate Compliance & Privacy Officer, Alaska Native Tribal Health Consortium
PAGE 14
Get Ready: RACs may be nationwide sooner than expected!
PAGE 4
Also:
Tax compliance for the new millennium: Redesigned Form 990—Part II
PAGE 46
Feature Focus:
Risk Assessments and Compliance
PAGE 22

Get Ready: RACs may be nationwide sooner than expected!

By: Andrew B. Wachler, Esq; Abby Pendleton, Esq; and Jessica L. Gustafson, Esq.

Editor's note: Andrew Wachler and Abby Pendleton are partners, and Jessica Gustafson is an associate, with the health care law firm of Wachler & Associates, PC, in Royal Oak, Michigan. They can be reached at 248/544-0888 or by e-mail at awachler@wachler.com, apendleton@wachler.com, and jgustafson@wachler.com.

Because of increased audit activity and scrutiny of claims by third-party payors, the financial pressure on hospitals, physicians, and other health care providers will not end anytime soon. To the contrary, as part of the Tax Relief and Health Care Act of 2006, Congress directed the expansion of the Recovery Audit Contractors (RAC) program to all 50 states by no later than 2010. However, the Centers for Medicare and Medicaid Services (CMS) plans to aggressively move forward with the expansion, with intentions for nationwide auditing to take place by spring 2008, three years ahead of schedule.

The original three-year RAC pilot demonstration project was a result of Section 306 of the Medicare Modernization Act, which directed CMS to investigate Medicare claims payment using RACs to identify overpayments and underpayments. The pilot demonstration project, which began in March of 2005, targeted the three states with the highest Medicare expenditures (New York, Florida, and California), and has proven highly successful from the financial perspective of CMS and the RACs. The CMS RAC Status Document for FY 2006 shows $303.5 million dollars in improper payments identified by the RACs, with a high percentage being linked to inpatient hospital claims.[1]

The RAC process seeks to identify and recover overpayments made by Medicare to medical providers. This process has ramifications that may significantly impact the financial status of providers. The current RAC experiences of many California hospitals highlight the significant impact that RACs will have on Medicare providers as the project goes nationwide. Providers have found the RAC process burdensome, because significant resources have been dedicated to responding to volumes of record requests and defending claims denials.

While RACs are responsible for detecting medical underpayments as well as overpayments, it is the process of recouping overpayments that is of particular importance to hospitals, physicians, and other provider types. The RAC auditors will be searching for overpayments, including payment errors, diagnostic related group (DRG) and coding errors, non-covered services, medically unnecessary services, duplicate or incorrectly coded claims, and medically unlikely edits, and technical denials.

Notably, CMS compensates the RACs on a contingency fee basis, and the RACs are entitled to keep their fee if the denial is upheld at the first level of Medicare appeal (i.e., redetermination to the Carrier or Fiscal Intermediary [FI]) regardless of whether the provider prevails at a later stage in the appeals process. This fee arrangement appears troublesome, because it provides incentives to private companies to aggressively review and deny claims. This includes denying claims which allege that services were not medically necessary or appropriately documented, areas that contain much subjectivity and are often highly disputed by the provider. CMS' payment agreement seems to guarantee that RACs will audit with a highly motivated work ethic to identify as many overpayments as possible.

While the RACs cannot review claims at random, they are authorized to use data analysis to identify which claims are likely to contain overpayments, a process called "targeted review." As a result, particular health care providers could potentially get hit with large volumes of requests.

Given what New York, Florida, and particularly California providers are experiencing in the pilot RAC project, Medicare providers are well advised to begin the process of preparing for RACs. Although providers may not be able to stop RAC audits, providers can engage in activities that should assist with the process. For example, providers need to prepare by dedicating resources to:

- internally monitor protocols to better identify and monitor areas that may be subject to review;
- respond to record requests within the required 45 days[2];
- compliance efforts including, but not limited to, documentation and coding education; and
- properly work up and defend denials in the appeals process. With regard to medical necessity and similar denials, this will clearly entail physician involvement, which many hospitals find difficult to obtain.

The appeals process

Claims denied as a result of a RAC audit are subject to the standard Medicare appeals process. Medicare providers should utilize the appeals process and should consider working

with qualified health care attorneys to make the best case possible. In addition to substantive arguments, such as attacking claim denials on the merits, it is important for providers to understand that other legal arguments and strategies exist and can be utilized in the appeals process. These legal arguments and strategies may prove invaluable to the case. For example, the Social Security Act contains provisions, such as the Medicare Provider Without Fault and Waiver of Liability provisions, which can be used and developed with certain facts and circumstances that may exist in the case. Moreover, it may be appropriate in many appeals to assert the "Treating Physician Rule," which involves the legal principle that the treating physician, who has examined the patient and is most familiar with the patient's condition, is in the best position to make medical necessity determinations.

In 2005, a new uniform Medicare appeals process was created, resulting in the same appeals process for both Part A and Part B providers. This process includes:

- a redetermination appeal to the Carrier or FI,
- a reconsideration submitted to a Qualified, Independent Contractor (QIC),
- an appeal to an Administrative Law Judge (ALJ),
- an appeal to the Medicare Appeals Council (MAC), and
- an appeal to federal district court.

To pursue the various levels of appeal, certain requirements must be met at certain stages in the appeals process. Although many providers have not seen much success at the redetermination stage of the appeal, the later stages of appeal, particularly the ALJ stage, may prove more successful. Providers must use due care in complying with the timeframes and other requirements set forth in the appeals process. Failure to do so may result in the inability to pursue the appeal.

The first level in the appeals process is redetermination. Health care providers must submit redetermination requests in writing within 120 calendar days of receiving notice of an initial determination. There is no amount-in-controversy requirement.

The second level of appeal must be filed within 180 calendar days of receiving notice of the redetermination decision. Providers dissatisfied with a Carrier's or FI's redetermination decision may file a request for reconsideration to be conducted by the QIC. As with the redetermination stage, there is no amount-in-controversy requirement.

The QIC reconsideration stage of appeal has important ramifications for both Part A and Part B providers. For Part A providers, the QIC reconsideration constitutes an additional step in the appeals process that was not afforded under prior regulations. With respect to Part B providers, the QIC reconsideration stage replaces the in-person Carrier Hearing that was part of the prior regulations. One important negative change for Part B providers is that the QIC reconsideration is an "on-the-record" review, rather than an in-person hearing. The previous process afforded Part B providers with an actual in-person hearing.

Moreover, it is important to note that the reconsideration stage of the appeals process contains an early-presentation-of-evidence requirement. This means that a provider's failure to submit evidence to the QIC at the reconsideration stage of appeal will likely preclude the provider from introducing the evidence to an ALJ or at later stages in the appeals process. Accordingly, it will be crucial for providers to fully work up their cases at the reconsideration stage of appeal. Many issues are raised by the early-presentation-of-evidence requirement. For example, if in-person expert testimony cannot take place at the reconsideration stage of appeal, will the provider be required to submit affidavits or other written testimony at the QIC level in order to introduce expert testimony at an ALJ hearing?

The third level of appeal is the ALJ hearing. A provider who is dissatisfied with a reconsideration decision may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC's decision and must meet the amount-in-controversy requirement. In addition, a provider may exercise the escalation provisions of the Medicare appeals regulations to request an ALJ hearing, if the QIC fails to issue a decision within the requisite time frame.

ALJ hearings can be conducted by video-teleconference (VTC), in-person, or by telephone. The final rule requires the hearing to be conducted by VTC if the technology is available; however, if VTC is unavailable, or in other extraordinary circumstances, the ALJ may hold an in-person hearing. Additionally, the ALJ may offer a telephone hearing. Notably, the provider is not automatically entitled to an in-person hearing at the ALJ stage of appeal.

The fourth level of appeal is the MAC review. The MAC is within the Departmental Appeals Board of the U.S. Department of Health and Human Services. A MAC review request must be filed within 60 days following receipt of the ALJ's decision. Additionally, a provider may exercise the escalation provisions of the Medicare appeals regulations to request MAC review if the ALJ fails to issue a decision within the requisite time frame. Among other requirements, a request for MAC review must identify and explain the parts of the ALJ action with which the provider disagrees. Unless the request is from an unrepresented beneficiary, MAC will limit its review to the issues raised in the written request for review.

Continued on page 7

The final step in the appeals process is judicial review in federal district court, which must be filed within 60 days of receipt of the MAC's decision. A provider also may exercise the escalation provisions of the Medicare appeals regulations to request federal district court review of a claim denial. In a federal district court action, the findings of fact by the Secretary of Health and Human Services are deemed conclusive if supported by substantial evidence.

Summary

CMS has announced its intention to aggressively expand the RAC pilot demonstration project, with plans for nationwide auditing to begin as early as spring 2008. The contingency payment arrangement between CMS and the RACs ensures that the RACs will aggressively audit providers, with an eye towards denying as many claims as possible. Providers are well advised to act now to prepare for the expansion of RAC activity. Providers should dedicate resources towards compliance education and towards promptly addressing any document requests and/or claim denials made by RACs, Carriers, or FIs. Because claim denials made by the RACs will be subject to the Medicare appeals regulations, providers must be cognizant of the recent changes made to these regulations and how they impact the rights of providers to challenge claim denials. For example, a provider that is unaware of the early-presentation-of-evidence requirement could be precluded from raising valid, and often successful, defenses as it moves through the appeals process. Providers should also be aware of the successful appeals strategies and defenses available to challenge claim denials. ■

1 November 22, 2006 CMS RAC Status Document FY 2006
2 Some providers have found it extremely difficult and burdensome to promptly respond to volumes of record requests. and provide the records to the RACs within 45 days of the request.

Be Sure to Get Your CHC CEUs

Inserted in this issue of **Compliance Today** is a quiz related to this article: "Get Ready: RACs may be nationwide sooner than expected!" by Andrew B. Wachler, Esq; Abby Pendleton, Esq; and Jessica L. Gustafson, Esq., beginning on page 4.

To obtain your CEUs, take the quiz and print your name at the top of the form. Fax it to Liz Hergert at 952/988-0146, or mail it to Liz's attention at HCCA, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. Questions? Please call Liz Hergert at 888/580-8373.

Compliance Today readers taking the CEU quiz have ONE YEAR from the published date of the CEU article to submit their completed quiz.