# Get ready for increased nationwide Medicare audit activity

## Business of Medicine

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The financial pressure on hospitals, physicians and other healthcare providers, as a result of increased scrutiny of claims and audit activity by third-party payors, will not end soon. To the contrary, as part of the Tax Relief and Health Care Act of 2006, Congress directed that the Medicare Recovery Audit Contractor (RAC) demonstration program expand to all 50 states by no later than 2010.

CMS plans to aggressively move forward with this expansion and has already announced the expansion of its program from three states to an additional nine states, with intentions for nationwide RAC auditing to take place by spring 2008 — three years ahead of schedule. Providers are well advised to prepare now for the expansion of the RACs and increasing Medicare audit activity.

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 payments using RACs to identify overpayments and underpayments. The pilot demonstration project, which began in March 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 (www.cms.hhs.gov/RAC/Downloads/RACStatusDocument—FY2006.pdf) reflects $303.5 million as total improper payments identified by the RACs for FY 2006, with a high percentage being linked to inpatient hospital claims.

The RAC process is designed to identify and recover overpayments (and underpayments) made by Medicare to providers. This process has ramifications that may significantly impact the financial status of providers. The current RAC experiences of many California hospitals highlights the significant impact the RACs will have on Medicare providers as the project goes nationwide. To date, providers have found the RAC process burdensome; 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 overpayments for which the RAC auditors will be searching include payment errors, diagnostic related group (DRG) and coding errors, noncovered services, medically unnecessary services, duplicate or incorrectly coded claims, and medically unlikely edits and technical denials.

Notably, CMS compensates RACs on a contingency-fee basis, and RACs are entitled to keep their fee if a denial is upheld at the first level of Medicare appeal (i.e., redetermination to the Carrier or Fiscal Intermediary), regardless of whether the provider prevails at a later stage in the appeals process. Amazingly, subsequent appeals after the first level of appeal do not impact a RAC's ability to retain the contingency payment.

This fee arrangement appears troublesome, as it provides incentives to private companies to aggressively review and deny claims. This includes denying claims alleging 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 likely contain overpayments, a process called "targeted review." As a result, particular healthcare providers could potentially get hit with large volumes of requests.

Given what New York, Florida, and especially California providers are experiencing in the pilot RAC demonstration project, Medicare providers are well advised to begin the process of preparing for the RACs now. 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:

- Internal monitoring protocols to better identify and monitor areas that may be subject to review
- Responding to record requests (some providers have found it extremely difficult and burdensome to timely respond to volumes of record requests; this will be particularly important given that providers are required to provide the records to the RACs within 45 days of the request)
- Compliance efforts including, but not limited to, documentation and coding education
- Dedicating personnel and resources to 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

### Medicare appeals process

Notably, 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 healthcare attorneys in order 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, that 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 Intermediary
- 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)
- An appeal to Federal district court.

In order to pursue the various levels of appeal, certain requirements must be met a 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.

As noted above, the first level in the appeals process is redetermination. Providers must submit a redetermination request in writing within 120 calendar days of receiving notice of an initial determination. There is no amount in controversy requirement.

Providers dissatisfied with a Carrier's or Intermediary's redetermination decision may file a request for reconsideration to be conducted by the QIC. This second level of appeal must be filed within 180 calendar days of receiving notice of the redetermination decision. 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 afforded under the prior regulations. In an important negative change for Part B providers, 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, as many providers may be unaware, 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 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.

The third level of appeal is the ALJ hearing. A provider 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. 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. 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, the MAC will limit its review to the issues raised in the written request for review.

The final step in the appeals process is judicial review in federal district court. A request for review in district court must be filed within 60 days of receipt of the MAC's decision. In a federal district court action, the findings of fact by the Secretary of HHS are deemed conclusive if supported by substantial evidence.