

# **RECOVERY AUDIT CONTRACTORS AND MEDICARE AUDITS: SUCCESSFUL STRATEGIES FOR DEFENDING AUDITS**

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## **I. INTRODUCTION**

Attention radiology providers: Get ready for increased Medicare auditing activity! The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program has been made permanent and is expanding nationwide, beginning this year. Claim denials and overpayment determinations made by RACs are subject to the Medicare appeals process. Radiology providers are well advised to understand the Medicare appeals process and should recognize that there are many effective strategies that can be successfully employed in the appeals process.

## **II. RECOVERY AUDIT CONTRACTORS**

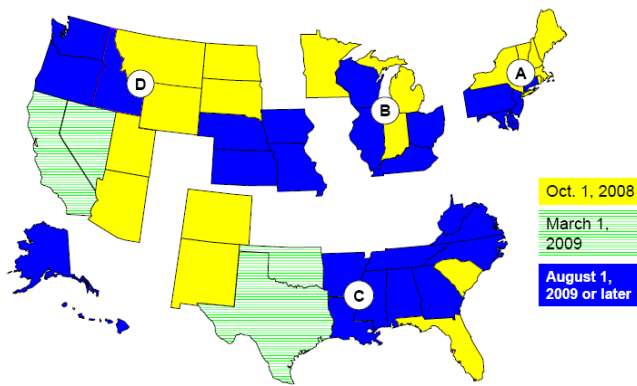
Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), directed the Department of Health and Human Services (HHS) to conduct a three-year demonstration program using RACs. The demonstration began in 2005 in the three states with the highest Medicare expenditures: California, Florida and New York. In 2007, the RAC demonstration program expanded to include Massachusetts, South Carolina and Arizona. The purpose of the demonstration program was to determine whether the use of RACs would be a cost-effective way to identify and correct improper payments in the Medicare program.

The RAC demonstration program proved highly “cost effective” from the point of view of CMS. Over the course of the three-year demonstration, the RACs identified and collected

more than \$1.03 billion in improper payments. According to CMS, factoring in the underpayments returned to providers and suppliers, the claims overturned on appeal, and the operating costs of the demonstration program, the RAC program was successful in returning \$693.6 million to the Medicare Trust Funds. CMS estimates that the RAC demonstration program cost approximately 20 cents for each dollar returned to the Medicare Trust Funds.<sup>1</sup>

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent, and required its expansion nationwide by no later than 2010. CMS is actively moving forward with this expansion. According to its most-recently published “Expansion Schedule,” CMS planned to expand to 19 states by October 1, 2008, four more states by March 1, 2009, and the remaining states by August 1, 2009 or later.<sup>2</sup>

### RAC Expansion Schedule



On October 6, 2006, CMS announced the names of the RAC vendors for the permanent program, and identified the initial states for which each will be responsible:

- Diversified Collection Services, Inc., of Livermore California is the RAC for Region A, including Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York;
- CGI Technologies and Solutions, Inc. of Fairfax, Virginia is the RAC for Region B, including Michigan, Indiana and Minnesota;

- Connolly Consulting Associates, Inc. of Wilton, Connecticut is the RAC for Region C, including South Carolina, Florida, Colorado and New Mexico; and
- HealthDataInsights, Inc. of Las Vegas, Nevada is the RAC for Region D, including Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.<sup>3</sup>

Before the permanent RACs begin their auditing activities, in October and November 2008, the RACs will hold “Town Hall”-type outreach meetings, at which the RACs will meet with representatives from CMS and with Medicare providers and suppliers. Soon after these outreach meetings are completed, Medicare providers and suppliers in the first 19 states can expect to receive requests for medical records and/or overpayment demand letters from the RACs.<sup>4</sup>

Although RACs are responsible for correcting underpayments as well as overpayments, it is the process of recouping alleged overpayments that is of particular significance to Medicare providers. RACs may make determinations regarding coverage, coding and other technical issues (e.g. duplicate claims). The RACs are permitted to attempt to identify improper payments resulting from any of the following:

- Incorrect payments;
- Non-covered services (including services that are not reasonable and necessary);
- Incorrectly coded services; and
- Duplicate services.<sup>5</sup>

When performing coverage or coding reviews of medical records requested from a Medicare provider or supplier, nurses (RNs) or therapists are required to make determinations regarding medical necessity and certified coders are required to make coding determinations.

The RACs are not required to involve physicians in the medical record review process.

However, the RACs are required to employ a minimum of one FTE contractor medical director

(CMD), who is a doctor of medicine or doctor of osteopathy, and arrange for an alternate CMD in the event that the CMD is unavailable for an extended period. The CMD will provide services such as providing guidance to RAC staff regarding interpretation of Medicare policy.

Although the RACs have fairly broad discretion in determining which claims to review for the purposes of identifying payment errors, CMS has prohibited the RACs from looking at certain categories of claims. For example:

- The permanent RAC program will begin with a review of claims paid on or after October 1, 2007. This first permissible date for claims review is the same for the RAC reviews in all states, regardless of the actual start date for a RAC in a particular state. However, as time passes, the RACs will be prohibited from reviewing claims more than three years past the date of initial determination (defined as the initial claim paid date).
- RACs are not permitted to review claims at random. However, RACs are authorized to use “data analysis techniques” to identify claims likely to be overpayments, a process called “targeted review.” The permanent RACs, like those in the demonstration program, will likely consider their “data analysis techniques” to be proprietary, and thus will not tell providers the types of claims they will be reviewing. In the demonstration program, the “targeted review” resulted in certain categories of providers being subject to larger volumes of record requests and corresponding claim denials than other provider types (e.g. Inpatient Rehabilitation Facility providers were subject to very high volumes of record requests and received numerous claim denials).<sup>6</sup>

CMS compensates the RACs on a contingency fee basis, based upon the principal amount of collection (or the amount paid back to) a provider. This fee arrangement provides incentives to the RACs to aggressively review and deny claims, including claims that the RAC alleges to be not “medically necessary,” an area containing much subjectivity, and a category of denial often highly disputed by the provider. Over the course of the three-year demonstration, the RACs identified and collected \$992.7 million in overpayments and ordered repayment of just \$37.8 million in underpayments to Medicare providers and suppliers.<sup>7</sup> Thus, approximately 96 percent of the alleged improper payments identified were overpayments, as opposed to underpayments.

In a significant change from the demonstration program, under the permanent RAC program, if a provider files an appeal disputing the overpayment determination, and provider wins this appeal at any level, the RAC is not entitled to keep its contingency fee, and must repay CMS the amount it received for the recovery.<sup>8</sup>

Medicare providers nationwide are well advised to begin preparing for the RACs and increased Medicare auditing activity now. Although providers cannot stop RAC audits from happening, radiology providers can begin to prepare by dedicating resources to:

- Internally monitoring protocols to better identify and monitor areas that may be subject to review;
- Responding to record requests within the required timeframes;
- Implementing compliance efforts, including but not limited to, documentation and coding education. Notably, in addition to claim denials resulting from medical necessity and improper documentation and coding, it also is possible to receive claim denials if services are not provided in a manner consistent with Medicare regulations. Therefore, radiology providers should ensure that the services provided are appropriately documented and coded, and also ensure that the provider is compliant with Stark, the Anti-markup rule, the teleradiology rules, and the corporate practice of medicine doctrine, among other rules; and
- Properly working up appeals to challenge denials in the appeals process. With regard to medical necessity and similar denials, this will clearly entail physician involvement, which many non-physician providers and suppliers find difficult to obtain.

### **III. MEDICARE AUDITS – The Medicare Appeals Process**

If a Medicare provider receives a claim denial or a finding of overpayment is made as a result of a RAC review, the denial will be subject to the standard Medicare appeals process. The regulations governing the uniform Medicare Part A and Part B appeals process are contained in 42 C.F.R. Part 405, subpart I.

#### **A. Stage 1: Redetermination**

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

**B. Stage 2: Reconsideration**

Providers dissatisfied with a carrier's redetermination decision may file a request for reconsideration to be conducted by a Qualified Independent Contractor (QIC). This second level of appeal must be filed within 180 calendar days of receiving notice of the redetermination decision. There is no amount in controversy requirement.

Prior to the establishment of the new appeals process, Part B providers, such as radiology providers, were afforded an in-person Carrier Hearing upon receiving an initial determination from the carrier. The QIC reconsideration replaces the Carrier Hearing. Importantly, the QIC reconsideration is an "on-the-record" review, contrary to an in-person hearing review. In conducting its review, the QIC will consider evidence and findings upon which the initial determination and redetermination were based plus any additional evidence submitted by the parties or the QIC obtains on its own.

Of particular note, providers must submit a full and early presentation of evidence in the reconsideration stage. When filing a reconsideration request, a provider must present evidence and allegations related to the dispute and explain the reasons for the disagreement with the initial determination and redetermination. Absent good cause, failure of a provider to submit evidence prior to the issuance of the notice of reconsideration precludes subsequent consideration of the evidence. Accordingly, providers may not be permitted to introduce evidence in later stages of the appeals process if such evidence was not presented at the reconsideration stage.

#### **IV. Stage 3: Administrative Law Judge Hearing**

The third level of appeal is the Administrative Law Judge (ALJ) hearing. A provider dissatisfied with a reconsideration decision or who has exercised the escalation provision at the reconsideration stage 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 regulations require 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.

#### **V. Stage 4: Medicare Appeals Council Review**

The fourth level of appeal is the Medicare Appeals Council (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 party disagrees. Unless the request is from an un-represented beneficiary, the MAC will limit its review to the issues raised in the written request for review.

Upon request, the MAC will grant the parties a reasonable opportunity to file briefs or written statements. Additionally, a party may request an opportunity to present oral argument. The MAC will grant this request if the case raises an important question of law, policy or fact that cannot be readily decided based upon the written submissions. If the MAC fails to issue a decision or remand the case within the mandatory timeframe, the provider may request the appeal be escalated to federal district court.

## **VI. Stage 5: Federal District Court**

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.

### **A. STRATEGIES FOR DEFENDING MEDICARE AUDITS**

Medicare providers subject to RAC or other Medicare audits should understand that many strategies exist that can be employed successfully in the appeals process to effectuate meaningful results. These strategies involve effectively advocating the merits of the underlying services as well as employing legal defenses.

## **VII. Advocating the Merits**

When advocating the merits of a claim, healthcare legal counsel assisting radiology providers often find it useful to draft a position paper outlining the factual and legal arguments in support of payment for a disputed claim. In addition, in most cases it is advantageous to engage the services of a qualified expert. Appropriate use of an expert can prove very useful, particularly when the audit involves medical necessity denials. In arguing the merits, other strategies that can prove successful include the use of medical summaries, illustrations, and other types of color-coded charts or graphs depicting the claims at issue that are user-friendly for the decision maker.

## **VIII. Audit Defenses**

In addition to advocating the merits of a claim through various techniques, certain legal defenses are available. Defenses that have proven valuable for providers challenging Medicare audit determinations include: invoking the treating physician rule, arguing the "Waiver of



Liability” defense, arguing the provider is without fault, challenging the timeliness of the audit and/or claim denial, and challenging the statistical extrapolation (if one was involved).

*a. Treating Physician Rule*

It may be appropriate in many audit settings to assert the “treating physician rule.” The treating physician rule 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. The treating physician rule, as adopted by some courts, reflects that the treating physician’s determination that a service is medically necessary is binding unless contradicted by substantial evidence, and is entitled to some extra weight, even if contradicted by substantial evidence, because the treating physician is inherently more familiar with the patient’s medical condition. Thus, providers should reference the treating physician rule to demonstrate that the treating physician’s medical judgment as to the medical necessity of the services provided should prevail absent substantial contradictory evidence. With reference to radiology providers specifically, it should be noted that the determination whether a radiology service is reasonable and necessary is often initially made by a referring physician that orders radiology services rendered by a radiology provider. This is an important consideration that should be addressed in a discussion of the treating physician rule.

*b. Waiver of Liability*

Pursuant to the Medicare waiver of liability defense, physicians may be entitled to payment for claims deemed not reasonable and necessary by the carrier during an audit. The statutory authority for waiver of liability is set forth in Section 1879(a) of the Social Security Act.<sup>9</sup> Under waiver of liability, even if a service is determined to be not reasonable and necessary, nonetheless payment may be rendered if the provider did not know and could not

reasonably have been expected to know payment would not be made. The relevant inquiry focuses on whether the provider “knew or could have reasonably been expected to know” payment would not be made. Therefore in defending an audit, a physician must have access to all relevant Carrier communications with the provider community and communications with the particular provider. The waiver of liability provisions generally only apply to determinations that a service was not medically necessary. If a radiology service is denied as not reasonable and necessary, one potential argument a radiology provider could make under the theory of waiver of liability is that it did not know, and could not reasonably have been expected to know that payment would not be made on the claim, because the referring physician had specifically determined that the services would be reasonable and necessary for the care of the patient.

*c. Provider without Fault*

Additionally, the provider without fault defense may be employed in the case of post-payment review denials. The Medicare provider without fault provisions, Section 1870 of the Social Security Act, states that payment will be made to a provider if the provider was without “fault” with regard to billing for and accepting payment for disputed services.<sup>10</sup>

As a general rule, a provider will be considered without fault if he exercised reasonable care in billing for and accepting payment, i.e., the provider complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming the payment was correct.<sup>11</sup>

“Fault,” for purposes of the provider without fault provision, is defined as follows:

- (a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or
- (b) Failure to furnish information which he knew or should have known to be material; or

- (c) With respect to the overpaid individual only, acceptance of a payment, which he knew or could have been expected to know, was incorrect.<sup>12</sup>

As with waiver of liability, if a radiology service is denied as not reasonable and necessary, one argument a radiology provider could make under the provider without fault doctrine is that it did not know, and could not reasonably have been expected to know that payment would not be made on the claim, because the referring physician had specifically determined that the services would be reasonable and necessary for the care of the patient.

In addition, providers also will be deemed to be without fault in the absence of evidence to the contrary, if the overpayment was discovered subsequent to the third calendar year after the year of payment.<sup>13</sup>

*d. Reopening Regulations*

Medicare regulations recognize that, in the interest of equity, Medicare providers must be able to rely on coverage determinations. Accordingly, the Medicare regulations place restrictions upon the permissible timeframe for reopening determinations. According to the federal regulations governing the Medicare appeals process, once an initial determination to pay a claim has been made, the claim can be only reopened for review within a certain time period.

Pursuant to 42 C.F.R. § 405.980 (b), a contractor may reopen and revise its initial determination:

1. Within 1 year from the date of the initial determination for any reason;
2. Within 4 years of the date of the initial determination for good cause as defined in 405.986.
3. At any time if there exists reliable evidence as defined in Sec. 405.902 that the initial determination was procured by fraud or similar fault as defined in Sec. 405.902.

4. At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Pursuant to 42 C.F.R. § 405.986, “good cause” may be established when:

1. There is new and material evidence that—
  - i. Was not available or known at the time of the determination or decision; and
  - ii. May result in a different conclusion; or
2. The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.<sup>14</sup>

Further, according to the Medicare Financial Management Manual, “If an overpayment is determined based on a reopening outside of the above parameters, the FI or carrier will not recover the overpayment.”<sup>15</sup>

Although some Medicare providers experienced success challenging reopenings under these regulations during the RAC demonstration, providers should be aware that a recent MAC decision has found that the ALJ and MAC lack jurisdiction to consider challenges to reopenings under the Medicare appeals process.<sup>16</sup> Nonetheless, an argument exists that even if a provider or supplier may not challenge the Medicare contractor’s authority to reopen a claim, they may still be able to challenge the Carrier’s decision to “revise” that claim following the reopening.

*e. Challenges to Statistics*

In many post-payment audits, CMS will audit a small sample of a provider’s records and, if it finds an overpayment, CMS will extrapolate the overpayment to the provider’s entire patient population. The MMA sets limits regarding when statistical extrapolation may be used, and the Medicare manuals establish guidelines for CMS to follow when performing an audit based upon a statistical sample. If an extrapolation is flawed, it may be successfully challenged, bringing the

total dollars at issue to the “actual” alleged overpayment, and not the extrapolated alleged overpayment. For example, in one recent case challenged by this firm, CMS alleged an “actual” overpayment of approximately \$28,000, which it then extrapolated to render its determination that the provider had been overpaid over \$1.5 million. This firm was successful challenging the methodology of this statistical extrapolation and the extrapolation was overturned.

Pursuant to Section 935 of the MMA:

(1) LIMITATION ON USE OF EXTRAPOLATION. –A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that –

- (A) there is a sustained or high level of payment error; or
- (B) documented educational intervention has failed to correct the payment error.

CMS also has established guidelines for statistical extrapolations, which are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08, Chapter 3, §§ 3.10.1 through 3.10.11.2). Notably, the RACs are authorized to use extrapolation, provided that they adhere to the above-referenced statute and Manual provisions.<sup>17</sup> CMS must follow these guidelines in conducting statistical extrapolations. If it fails to do so, a Medicare provider may have success challenging the validity of the extrapolation.

## **IX. CONCLUSION**

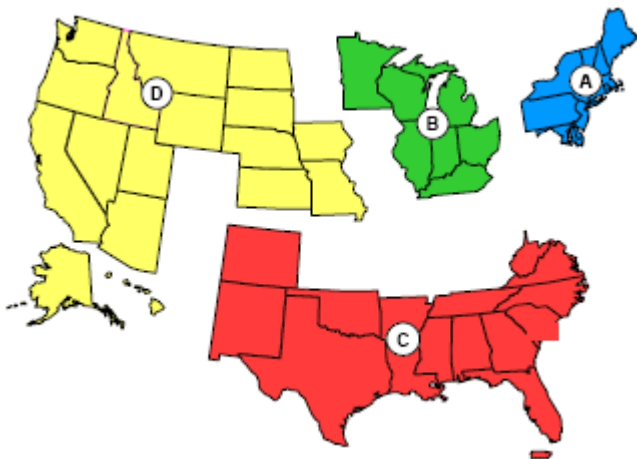
Radiology providers should be ready for increased Medicare auditing activity as the RAC program expands nationwide. Radiology providers should make efforts now to evaluate their compliance with Medicare policy. Should a provider or supplier be subject to a RAC or other Medicare audit, effective strategies are available that can be successfully employed in the appeals process to defend Medicare audits.



<sup>1</sup> The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 15, June 2008, available at [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>2</sup> RAC Expansion Schedule, available at <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

<sup>3</sup> The regions for the permanent RAC program are as follows:



[http://www.cms.hhs.gov/RAC/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/RAC/01_Overview.asp#TopOfPage)

<sup>4</sup> 2008 RAC Fact Sheet, available at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

<sup>5</sup> RAC Statement of Work, available at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp#TopOfPage](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage) (last accessed June 4, 2008).

<sup>6</sup> *Id.*

<sup>7</sup> “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at p. 15, June 2008, available at [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf).

<sup>8</sup> RAC Statement of Work, available at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp#TopOfPage](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage) (last accessed June 4, 2008).

<sup>9</sup> 42 U.S.C. § 1395pp. See also Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 30, § 20.

<sup>10</sup> 42 U.S.C. § 1395gg.

<sup>11</sup> Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 3, § 70.3.

<sup>12</sup> 20 C.F.R. § 404.507.

<sup>13</sup> Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, §§ 80 and 90.

<sup>14</sup> See also Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 29, § 90 and Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1

<sup>15</sup> Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1.

Although providers have experienced success challenging reopenings under these regulations, providers should be aware that a recent Medicare Appeals Council decision has found that CMS lacks jurisdiction to consider challenges to

reopenings under the Medicare appeals process. See *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*, decided February 29, 2008.

<sup>16</sup> *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*, decided February 29, 2008.

<sup>17</sup> RAC Statement of Work, available at [http://www.cms.hhs.gov/RAC/10\\_ExpansionStrategy.asp#TopOfPage](http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage) (last accessed June 4, 2008).