DEALING WITH RAC DENIALS:

THINKING STRATEGICALLY ABOUT WHAT AND WHETHER TO APPEAL

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RAC PROGRAM MISSION

- DETECT AND CORRECT PAST IMPROPER PAYMENTS
- SO THAT CMS AND ITS AGENTS CAN IMPLEMENT ACTIONS TO HELP PREVENT FUTURE IMPROPER PAYMENTS

RACs USE 2 APPROACHES TO REVIEWING FOR IMPROPER PAYMENTS

I. AUTOMATED REVIEW

- DATA MINING
  - CERTAINTY THAT SERVICE IS NOT COVERED OR IS INCORRECTLY CODED AND
  - A WRITTEN MEDICARE POLICY, ARTICLE OR SANCTIONED GUIDELINE EXISTS

RACs USE 2 APPROACHES TO REVIEWING FOR IMPROPER PAYMENTS (cont.)

II. COMPLEX REVIEW

- HUMAN REVIEW OF THE MEDICAL RECORD
  - THE REQUIREMENTS FOR AUTOMATED REVIEW ARE NOT MET (E.G., NO MEDICARE POLICY, ARTICLE OR SANCTIONED CODING GUIDELINES EXISTS)
  - THERE IS A HIGH PROBABILITY (BUT NOT CERTAINTY) THAT A SERVICE IS NOT COVERED

HISTORY LESSONS

APPEALS IN THE DEMONSTRATION PROJECT (PER JANUARY 2009 CMS UPDATE, PARTS A AND B CLAIMS COMBINED)

- 525,133 CLAIMS WITH OVERPAYMENT DETERMINATIONS
- 22.5% APPEALED (8.5% JUMP BETWEEN 3/08 AND 8/08)
- 34% OF APPEALED CLAIMS DECIDED IN PROVIDERS' FAVOR (16% DROP FROM 9/07)
- PART B CLAIMS HAD SLIGHTLY HIGH REVERSAL RATE (35.1% VS. 32.8%)

HISTORY LESSONS

Appendix E

Overpayments Collected by Error Type and Provider Type

TABLE E1. Overpayments Collected by Error and Provider Type (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only (Percent of Total)

Error Type	Inpatient Hospital	Inpatient Rehabilitation Facility	Skilled Nursing Facility	Out-Patient Hospital	Physician	Ambulance/ Lab/Other	Durable Medical Equpment	Total Overpayments Collected
Medically Unnecessary	34.5	5.63	0.26	0.47	0.00	0.00	0.00	40.86
Incorrectly Coded	30.48	0.00	0.62	2.44	1.05	0.06	0.00	34.66
No/Insufficient Documentation	6.63	0.44	0.48	0.11	0.00	0.00	0.09	7.76
Other	12.57	0.00	0.41	1.22	1.44	0.45	0.63	16.72
Total	**84.19**	**6.07**	**1.76**	**4.25**	**2.50**	**0.51**	**0.72**	**100.00**

Note: These percentages are net of appeals and thus vary slightly from the data shown in other sections of the report.
Source: Self-reported by the Claim RACs.

A NEW WORLD?

- NEW ISSUES TO BE POSTED TO THE WEB
- CLINICAL REVIEWERS MANDATORY
  - MEDICAL DIRECTORS
  - CERTIFIED CODERS
- MANDATORY DISCUSSION WITH MEDICAL DIRECTOR RE CLAIM DENIALS ON REQUEST
- VALIDATION REVIEWS OF ACCURACY OF RAC OVERPAYMENT DETERMINATIONS
- OUTREACH EFFORTS
- RAC LOSES CONTINGENCY FEE IF PROVIDER PREVAILS ON APPEAL

WHAT ARE THE COMMON APPEAL STRATEGIES?

- THE KITCHEN SINK STRATEGY: APPEAL EVERYTHING

- THE "I'M RIGHT" STRATEGY: APPEAL ALL CASES WHERE ORIGINAL BILLING IS SUPPORTABLE

WHAT ARE THE COMMON APPEAL STRATEGIES? (cont'd)

- THE "COST/BENEFIT STRATEGY":
  APPEAL ONLY AFTER COST/BENEFIT ANALYSIS

- THE "CUSTOMIZED" STRATEGY:
  FOCUS ON DENIALS OF HIGH VOLUME, HIGH DOLLAR CLAIMS

- ROLE OF DISCUSSION PERIODS

ALL BUT THE KITCHEN SINK STRATEGY CONSIDER THE EVIDENTIARY SUPPORT FOR THE APPEAL

TWO BITES AT THE APPLE?

DISCUSSION/REBUTTAL PERIOD WITH RAC

- UPON RAC DENIAL: ACCEPT, OR DISCUSS AND/OR APPEAL
- DISCUSS/REBUT
  - AFTER RECEIPT OF RAC'S RESULTS REVIEW LETTER (COMPLEX) OR DEMAND LETTER (AUTOMATED)
  - ACCESS TO RAC MEDICAL DIRECTOR
  - CAN SUBMIT STATEMENT AND ADDITIONAL MATERIALS
  - REVIEW BY RAC REVIEWER WHO WAS NOT INVOLVED IN THE ORIGINAL IMPROPER PAYMENT DETERMINATION
  - POSSIBLE USE TO AUGMENT PROVIDER'S UNDERSTANDING OF THE BASIS FOR THE DENIAL AND IN ASSESSING WHETHER TO APPEAL

DISCUSSION PERIOD (cont'd)?

- OPPORTUNITY TO OFFER RESULTS OF PRIOR REBUTTALS OR APPEALS OR TECHNICAL FOULS, SUCH AS CLAIM UNDER REVIEW BY ANOTHER CMS AUDITOR
- REFERENCE ANY MEDICARE AUTHORITY SUPPORTING PROVIDER'S POSITION
- PROVIDER STILL ABLE TO APPEAL, BUT USE OF REBUTTAL DISCUSSION IS SEPARATE FROM THE APPEAL PROCESS AND DOES NOT ALTER RECOUPMENT OR APPEAL TIME FRAMES

DO YOU APPEAL A RAC DENIAL?

IS THE APPEAL VIABLE?

- ANY CLEAR MEDICARE RULES, GUIDANCE OR CRITERIA REGARDING THE SERVICE
- STATUS OF SUPPORTING DOCUMENTATION
- CLINICAL STAFF AVAILABILITY AND SUPPORT
- INVOLVEMENT OF OUTSIDE CONSULTANTS/ ATTORNEYS TO ASSIST IN REVIEW OF DENIAL

DO YOU APPEAL A RAC DENIAL? (cont'd)

- QUESTION OF THE BASIS OF THE LEGAL AUTHORITY USED BY THE RAC AND THE EFFECT OF BINDING AUTHORITY ON DIFFERENT APPEAL LEVELS
  - ALJS NOT BOUND BY LOCAL COVERAGE DECISIONS, LOCAL MEDICAL REVIEW POLICIES, OR CMS PROGRAM GUIDANCE; E.G., MANUAL PROVISIONS
- AVAILABILITY OF OTHER LEGAL DEFENSES
- COST VS. BENEFIT OF THE APPEAL

DO YOU APPEAL A RAC DENIAL? (cont'd)

TECHNICAL FOULS?

- DOES RAC AUDIT COMPLY WITH RAC CONTRACTUAL REQUIREMENTS?
  - *EXAMPLE*: NO REVIEW OF CLAIMS REVIEWED BY OTHER MEDICARE AUDITORS OR FEDERAL AGENCIES
  - *EXAMPLE*: CANNOT EXCEED CMS ISSUED LIMITS ON NUMBER AND FREQUENCY OF MEDICAL RECORD REQUESTS
  - *EXAMPLE*: DID RACs INVOLVE APPROPRIATE CLINICAL STAFF IN REVIEW
  - *EXAMPLE*: DID RAC APPLY CMS RULES/POLICIES OR ITS OWN SCREENING CRITERIA AND RULES

COST VERSUS BENEFITS OF APPEALING

BENEFITS

A. NO RECOUPMENT FOR FIRST 2 APPEAL LEVELS IF SO ELECT AND APPEAL WITHIN 30 DAYS OF DEMAND LETTER

B. MAY HEAD OFF SIMILAR DENIALS, IF SUCCESSFUL

C. DEFEND AGAINST POSSIBLE RAC EXTRAPOLATIONS

D. MINIMIZE COMPLIANCE REPERCUSSIONS FROM NOT CHALLENGING DENIALS

E. PROTECT COMMUNITY REPUTATION

F. INDUSTRY-WIDE BENEFITS

COST VERSUS BENEFITS OF APPEALING (cont'd)

- COSTS
  - COST OF ASSESSING THE DENIAL
    - INTERNAL
    - EXTERNAL CONSULTANTS OR LEGAL COUNSEL
  - COST OF PREPARING AND HANDLING THE APPEAL
    - ALJ (THE THIRD LEVEL APPEAL) IS GENERALLY THE MOST FRIENDLY APPEAL LEVEL, BUT DOCUMENTATION EVIDENCE MUST BE COMPLETE BY THE SECOND LEVEL (RECONSIDERATION)
    - PROVISION OF DOCUMENTATION THEREAFTER IS SUBJECT TO "GOOD CAUSE" CONSIDERATIONS
  - CONSIDER COSTS OF THE INDIVIDUAL CLAIM VERSUS AGGREGATED APPEAL OF SIMILAR CLAIMS VERSUS APPEALS OF DENIALS OF THE ENTITY'S HIGH VOLUME CLAIMS

RECOUPMENT AND INTEREST COSTS

- IF APPEAL EARLY, AVOID IMMEDIATE RECOUPMENT
  - SECTION 935 OF THE MMA: RECOUPMENT UNLESS REQUEST REDETERMINATION BY THE 30TH DAY AFTER THE DATE OF THE DEMAND LETTER AND UNLESS REQUEST RECONSIDERATION BY THE 60TH AFTER AN ADVERSE REDETERMINATION DECISION
  - FILING DEADLINES SHORTENED, SO IMPACTS TIME TO ORGANIZE THE APPEAL
- PROTECTS IMMEDIATE CASH FLOW
  - *BUT*: PAY THE PIPER INTEREST LATER IF LOSE
- RECOUPMENT AFTER AN ADVERSE RECONSIDERATION DECISION EVEN IF APPEAL TO THE ALJ

RECOUPMENT AND INTEREST COSTS (cont'd)

- AND STILL COULD LOSE
  - LOSE PAYMENT FOR CLAIM

    PLUS
  - LOSE INTERNAL AND EXTERNAL RESOURCE COSTS

COMPLIANCE REPERCUSSIONS?

- RACs ARE TO REPORT SUSPECTED FRAUD AND ABUSE
- MMA OF 2003 DID NOT PROHIBIT INVESTIGATIONS BY CMS OF FRAUD AND ABUSE ARISING FROM A RAC OVERPAYMENT DETERMINATION
  - OTHER MEDICARE ENFORCEMENT AGENCIES WILL SEE THE DENIAL STATISTICS

COMPLIANCE REPERCUSSIONS? (cont'd)

- ERRONEOUS OR QUESTIONABLE RAC DETERMINATIONS MIGHT BE HARDER TO CHALLENGE AT THE BACK END IF THOSE DETERMINATIONS BECOME THE BASIS OF A COMPLIANCE INVESTIGATION
  - IF THE RAC FINDS OVERPAYMENTS OF A SYSTEMATIC TYPE, PROVIDER CORRECTIVE ACTIONS MERITED PARTICULARLY IF DO NOT APPEAL
  - IF DO APPEAL, THERE IS A LEGAL DISPUTE OVER WHETHER ANY KNOWLEDGE OF FALSITY UNDER THE FALSE CLAIMS ACT

COMPLIANCE REPERCUSSIONS? (cont'd)

- PREEMPTIVE ACTIONS BY THE PROVIDER
  - SELF-DISCLOSURES TO THE OIG
  - VOLUNTARY REFUNDS
  - CORRECTIVE ACTIONS TO MINIMIZE FUTURE IMPACT

COMPLIANCE REPERCUSSIONS? (cont'd)

- SELF-DISCLOSURE AND REPAYMENT
  - SHOULD A PROVIDER DISCOVER THAT IT MAY HAVE RECEIVED AN IMPROPER MEDICARE PAYMENT, MAY DECIDE TO MAKE A SELF-DISCLOSURE OR VOLUNTARY REFUND

COMPLIANCE REPERCUSSIONS? (cont'd)

- IMPACT ON RAC AUDITS:
  - RACs MAY NOT REVIEW CLAIMS THAT ARE UNDER REVIEW BY ANOTHER GOVERNMENT ENTITY
  - RAC COMPENSATION IS IMPACTED BY SELF-DISCLOSURES AND VOLUNTARY REFUNDS

COMPLIANCE REPERCUSSIONS? (cont'd)

- VOLUNTARY REPAYMENTS
  - MADE TO THE MEDICARE CONTRACTOR
  - NO RAC FEES IN CERTAIN CASES

SEE CMS RAC FAQs

Q: IF A PROVIDER PERFORMS A SELF AUDIT, HOW SHOULD THEY NOTIFY THE RAC?

A: IF A PROVIDER DOES A SELF-AUDIT AND IDENTIFIES IMPROPER PAYMENTS, THE PROVIDER SHOULD REPORT THE IMPROPER PAYMENTS TO THE APPROPRIATE MEDICARE CLAIMS PROCESSING CONTRACTOR. THE EXACT INFORMATION NECESSARY FOR THE SELF REFERRAL CAN BE DETERMINED BY CONTACTING YOUR LOCAL CARRIER, FI OR MAC. THERE ARE TWO TYPES OF SELF AUDITS. ONE IS COMMONLY CALLED A VOLUNTARY REFUND AND IS CLAIM BASED. IF THE REQUIRED CLAIM INFORMATION IS INCLUDED ALONG WITH THE AMOUNT OF THE IMPROPER PAYMENT, THE CLAIM WILL BE ADJUSTED BY THE CLAIM PROCESSING CONTRACTOR. THE RAC WILL BE AWARE OF THE ADJUSTMENT, BUT THE REFUND DOES NOT PRECLUDE FUTURE REVIEW. THE SECOND TYPE OF SELF AUDIT MAY INVOLVE THE USE OF EXTRAPOLATION. IF EXTRAPOLATION IS USED, THE CLAIM PROCESSING CONTRACTOR WILL REVIEW THE CASE FILE TO DETERMINE IF IT IS ACCEPTABLE. THE CLAIM PROCESSING CONTRACTOR WILL ACCEPT OR DENY THE EXTRAPOLATION FOR THE ISSUE IDENTIFIED BY THE PROVIDER. IF THE CLAIM PROCESSING CONTRACTOR ACCEPTS THE EXTRAPOLATION, THOSE CLAIMS IN THE UNIVERSE WILL BE EXCLUDED FROM RAC REVIEW.

SEE CMS RAC FAQs (cont'd)

- CMS CONTRACT SAYS RACs CAN EXTRAPOLATE
  - RACs MUST FOLLOW SECTION 935(a) OF THE MEDICARE MODERNIZATION ACT OF 2003
  - CMS ENVISIONS A RAC USING EXTRAPOLATION IN CASES WHERE THERE WAS EVIDENCE OF A SUSTAINED OR HIGH LEVEL OF PAYMENT ERROR OR DOCUMENTED EDUCATION INTERVENTION BY THE MEDICARE CONTRACTOR

OTHER CORRECTIVE ACTIONS

- IMPACT ON CLAIMS SUBMITTED IN THE FUTURE
- REDESIGNING OR IMPROVING INTERNAL CONTROLS
- EDUCATING AND TRAINING OF RELEVANT PROVIDER STAFF
- ASSURING POLICIES ON DOCUMENTATION CODING AND BILLING ARE UP TO DATE AND COMPLIANT
- PERIODICALLY MONITORING CLAIMS VIA AN INTERNAL AUDIT TO ASSURE THAT DOCUMENTATION, CODING AND BILLING IS BEING DONE APPROPRIATELY