



# HEALTH CARE FRAUD REPORT



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## RACs or Ruins: Lessons Learned From the RAC Demonstration Project

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### I. INTRODUCTION

**C**ongress enacted section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amidst growing evidence that the Medicare program issued substantial amounts of improper payments to Medicare providers and suppliers. This legislation directed the secretary of health and human services to demonstrate over a three-year period whether the use of Recovery Audit Contractors (RACs) could, in an efficient and accurate manner, detect and correct past improper payments in the Medicare fee-for-service program.<sup>1</sup>

<sup>1</sup> According to a January 2008 General Accounting Office Report, the Medicare program made an estimated \$10.8 billion dollars in improper payments for fiscal year 2007. See CMS Status Document FY 2007 Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program, at p. 7, available at <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf>

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The demonstration focused initially on California, New York, and Florida, the three states with the highest Medicare utilization. Providers and suppliers in these states were ill-prepared for the overwhelming demands from the RACs. Faced with the unplanned diversion of countless resources to revisit old claims, many failed to adequately and efficiently navigate through the multi-step Medicare appeals process, resulting in instances where the Medicare program recouped payment for services that were reasonable and medically necessary and met the Medicare coverage requirements.

The Secretary's reports portrayed the demonstration as being quite successful in identifying overpayment although providers may have reasons to disagree. Accordingly, Congress subsequently implemented Section 302 of the Tax Relief and Health Care Act of 2006, which mandated a permanent and nationwide RAC program by no later than Jan. 1, 2010.<sup>2</sup> It is imperative therefore, that providers and suppliers learn from the lessons of the RAC demonstration project and institute adequate measures to survive the permanent program.

After a brief discussion of the RAC demonstration and permanent programs and an overview of the Medicare Part A and Part B appeals process, this article will focus on the lessons learned during the demonstration project and the necessary steps that providers and suppliers will need to implement so they can work with the RACs both effectively and efficiently.

### II. THE RAC DEMONSTRATION PROJECT

Section 306 of the MMA directed the Secretary to demonstrate the efficacy of utilizing RACs to identify and correct Medicare underpayments and overpayments in both the post payment claim review process

<sup>2</sup> Section 1893(h) of the Social Security Act; 42 U.S.C. § 1395ddd.

and the Medicare Secondary Payer (MSP) system. The Centers for Medicare & Medicaid Services issued two Statements of Work, one for identifying and recouping Medicare Secondary Payer overpayments (Attachment J-1 in the SOW) and the second for identifying and recovering other overpayments (Attachment J-2 in the SOW).<sup>3</sup>

Congress authorized the demonstration to last no more than three years and include at least two states with the highest Medicare utilization. CMS started the demonstration project in California, Florida, and New York in March 2005. The Secretary awarded contracts to five RACs and, in accordance with Section 306(d) of the MMA, required the organizations to engage staff that had the appropriate clinical knowledge of, and experience with, Medicare payment rules and regulations or that they contract with an entity that met these qualifications.<sup>4</sup>

The demonstration project contracts, which were in place from March 2005 through March 2008, required the RACs to identify improper payments, including payments for services that were not medically necessary, excessive or insufficient payments for services that were incorrectly coded, duplicate payments, and payments for which another insurer was responsible. The contracts excluded physician evaluation and management services (level of service), hospice and home health, claims previously reviewed by another contractor, claims involved in a potential fraud investigation, claims paid within the past year, and claims more than four years past the date of the initial determination of the claim.

The RACs performed reviews through two methods—an automated review of claims data (no human review) and a complex review (human review of documentation such as the medical record). They were required to apply statutes, regulations, CMS national coverage, payment and billing policies as well as Local Coverage Determinations that have been approved by the Medicare claims processing contractors. They were not authorized to develop or apply their own coverage, payment, or billing policies.<sup>5</sup>

Following its review, the RAC was required to document the rationale for its determination, a list of the findings, and a description, if an overpayment existed,

<sup>3</sup> See “Statement of Work for the Recovery Audit Contractors Participating in the Demonstration” at p. 1, available at <http://subscript.bna.com/UTILS/lk.nsf/r/wpiy7pksc3?opendocument> or via <https://www.fbo.gov/index>

<sup>4</sup> Initially, each RAC had one jurisdiction, with PRG Schultz responsible for California, Health Data Insights in Florida, and Connolly Consulting in New York. In 2007, CMS expanded the demonstration project to include Massachusetts, South Carolina and Arizona. See “The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration,” at pages 1 and 11, 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); see also, CMS Status Document FY 2007 Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program, at p. 8, available at <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf>

<sup>5</sup> See generally, “Statement of Work for the Recovery Audit Contractors Participating in the Demonstration,” available at [http://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)

of the Medicare rule or policy violated.<sup>6</sup> CMS paid the RACs a contingency fee based on the amounts collected (or returned in the case of an underpayment) from the provider or supplier. The RAC retained its contingency fee from an overpayment determination unless the determination was reversed at the first level of the Medicare Appeals process even if the determination was subsequently overturned.<sup>7</sup>

### III. PERMANENT RAC PROGRAM

In its fiscal year 2007 Status Report, CMS announced that the RACs identified and corrected \$271 million dollars in improper Medicare payments, 96 percent of which were overpayments and the remaining 4 percent underpayments. In total, after taking into account the costs of the RAC program and monies returned from favorable appeals, CMS determined that the RACs returned approximately \$247.4 million dollars to the Medicare Trust Funds for fiscal year 2007.<sup>8</sup> These figures, however, failed to sufficiently account for the extensive number of pending appeals.

CMS recognized the importance of utilizing the RAC demonstration project to identify issues that needed to be remedied prior to the permanent program. Among these issues were a failure to maintain open lines of communication, inappropriate application of Medicare policies regarding medical necessity and recoupment of funds during the appeal process, and a failure to utilize qualified reviewers with sufficient physician reviewer oversight.<sup>9</sup>

Many of these lessons learned appear to have arisen from the reviews by the California RAC, PRG Schultz, of inpatient rehabilitation facility (“IRF”) claims. PRG Schultz reviewed claims from many California IRFs and denied thousands of claims involving millions of dollars. The IRF reviews led to a vigorous reaction from California hospitals and members of the California Congressional delegation.

In response, in his Dec. 7, 2007, letter to Rep. Lois Capps (D-Calif.), CMS acting Administrator Kerry N. Weems emphasized CMS’s commitment to developing a sound RAC process and stated:

“[I]t is clear that the RAC, fiscal intermediary, our independent review entity, as well as appeal contractors involved have not consistently applied our coverage and payment policies for inpatient rehabilitation services.”<sup>10</sup>

<sup>6</sup> *Id.* at p. 12. In the case of a partial denial, such as when the service was not reasonable or medically necessary, but would be at a lower level of service, the RAC was instructed to only issue an overpayment for the difference between the paid amount and the correct amount. *Id.* at p. 14.

<sup>7</sup> *Id.* at pages 16, 23-24.

<sup>8</sup> See CMS Status Document FY 2007 Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program, February 2008, at pages 11-12, available at <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf> See also, “The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration,” January 2009, available at <http://www.cms.hhs.gov/RAC/Downloads/AppealUpdateThrough83108ofRACEvalReport.pdf>

<sup>9</sup> *Id.*

<sup>10</sup> See Letter from Kerry Weems, CMS acting administrator, to the Honorable Lois Capps, House of Representatives, dated Dec. 7, 2007, and Letter from CHA Representatives John Riggs, vice president of Federal Regulatory Affairs and Patri-

As part of its commitment, CMS instituted a pause in the review of inpatient rehabilitation facility (IRF) claim reviews during the demonstration project, hired an independent contractor to review the RAC's performance in California, and ordered the RAC to re-review all of its IRF complex claim denials and issue repayments, if necessary.

cia Blaisdell, vice president for Medical Rehabilitation and Continuing Care Services to Kerry Weems, dated Dec. 20, 2007, available at <http://www.cms.hhs.gov/eRulemaking/downloads/CMS-2271-PPC1.pdf>;

The following chart further illustrates the differences between the RAC demonstration project and the new permanent RAC program.<sup>11</sup>

<sup>11</sup> See CMS Status Document FY 2007 Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program, February 2008, at pages 4-5, available at <http://www.cms.hhs.gov/RAC/Downloads/2007%20RAC%20Status%20Document%20vs1.pdf>; see also generally, "Statement of Work for the Recovery Audit Contractor Program," available at [http://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)

<b>DIFFERENCES BETWEEN RAC DEMONSTRATION PROJECT AND PERMANENT RAC PROGRAM</b>		
<b>Issues</b>	<b>Demonstration Project</b>	<b>Permanent RAC Program</b>
Look Back Period	Four Years	Three Years
Earliest Look Back	None	October 1, 2007
Current Year Claim	No	Yes
RAC Medical Director	Not Required	Mandatory
Certified Coders	Not Required	Mandatory
Medical Records Request	No mandatory limits	Mandatory limits
Access to Medical Director	Optional	Mandatory on provider request
Reporting to CMS	Limited	Frequent on problem areas identified
Contingency Fee Repayment	Only if overturned at first level of appeal	If overturned at any level
Web-Based Access	None	Mandatory Web-based application by 1/1/2010 that allows the provider to customize addresses and contact information or see the status of cases
Validation	Optional and varied by state	Mandatory and uniform

In addition, CMS will no longer recoup alleged overpayments before the provider or supplier receives a reconsideration decision (second level appeal) provided appeals are promptly filed, in accordance with Section 935 of the MMA.<sup>12</sup> Recoupment will commence unless a redetermination request (first level appeal) is filed by the 30th day after the date of the demand letter. Recoupment will commence following an unfavorable redetermination decision unless a reconsideration request is filed within 60 days of the decision. These timeframes are much shorter than the deadlines to file redetermination and reconsideration requests. Recoupment will occur after an unfavorable reconsideration decision even if there is a further appeal to an Administrative Law Judge.

Finally, CMS recently has "clarified" a legal issue that threatened to derail the demonstration project. According to 42 C.F.R. § 405.986, a contractor may reopen and revise an initial claim determination within one year for any reason, between one and four years for

good cause, and after four years upon a showing of fraud or similar fault.

The demonstration project reviews involved claims that had been paid at least one year before, so that most of the demonstration project denials involved reopenings that occurred within the one- to four-year timeframe, requiring a showing of good cause. Good cause exists when there is new and material evidence or an error on the face of the evidence used to make the initial determination.

Providers and suppliers argued successfully before Administrative Law Judges in many cases that the RACs failed to establish good cause to reopen claims since there was no evidence of new and material evidence that was not available to the contractor at the time of the initial determination. These decisions, however, have been routinely reversed by the Medicare Appeals Council (MAC), which has ruled that providers may not appeal a contractor's decision to reopen a claim, including whether the reopening was timely and supported by good cause, citing 42 C.F.R. § 405.926(l) and 42 C.F.R. § 405.980(a)(5). Rather, according to the MAC, a provider may only appeal the revised determination resulting from the reopening.

On Jan. 16, 2009, CMS issued a revision of the *Medicare Claims Processing Manual*, which addresses

<sup>12</sup> See MLN Matters Number MM6183, related to CR Transmittal #: R141 FM, effective Sept. 29, 2008, available at [www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6183.pdf)

claims reopenings. Effective Feb. 16, 2009, the claims processing manual provides that a contractor may on its own initiative or at the request of a party, reopen an initial determination or redetermination between one year and four years of the date of the initial determination or redetermination upon a finding of good cause.

New and material evidence is evidence that was not available or “known” to the person or entity requesting or initiating the reopening at the time of the determination or decision. Examples of new and material evidence include data analysis that identified a high error rate or pattern of overutilization by the provider or supplier and the medical record, if it was not utilized at the time of the initial determination.<sup>13</sup> Finally, adopting wholesale the controversial position of the MAC, the Medicare manual now states that a contractor’s decision that good cause exists to reopen a claim is not subject to appeal.<sup>14</sup>

CMS announced the names of the new national RACs on Oct. 6, 2008. The RACs include Diversified Collection Services Inc. for Region A, CGI Technologists and Solutions Inc. for Region B, Connolly Consulting Associates Inc. for Region C, and HealthDataInsights Inc. for Region D. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country.

However, shortly after the award of the RAC contracts, two of the unsuccessful bidders, PRG Schultz and Viant Payment Systems Inc., protested the contract awards. On Feb. 4, 2009, the parties informally resolved the protests, with PRG Schultz Inc. serving as a subcontractor for HDI, DCS, and CGI in regions A, B, and D, and Viant Payment Systems Inc. serving as a subcontractor to Connolly Consulting in Region C.<sup>15</sup>

The RAC permanent program will begin in some regions as early as March 2009.<sup>16</sup> In order to prepare providers and suppliers for the new program, CMS will work with national and state associations to take a more proactive stance as concerns may arise and hold Town Hall meetings with health care providers, CMS staff, and RAC representatives.<sup>17</sup>

#### IV. MEDICARE APPEALS PROCESS

Medicare providers and suppliers are entitled to appeal an adverse initial determination through a uniform Medicare Part A and B appeals process found in 42 C.F.R. § § 405.900 *et seq.* The following is a brief discussion of the five levels of appeal afforded to Medicare providers and suppliers.

<sup>13</sup> The authors view is that the change to the definition of good cause is not a clarification, but a substantive policy change that is at least arguably inconsistent with the applicable regulation.

<sup>14</sup> See “Clarification of Requirements for New and Material Evidence as Good Cause for Reopening,” *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal No. 1671, Jan. 16, 2009.

<sup>15</sup> See [http://www.cms.hhs.gov/RAC/01\\_Overview.asp](http://www.cms.hhs.gov/RAC/01_Overview.asp) A map of the RAC jurisdictions is available at <http://www.cms.hhs.gov/RAC/Downloads/Four%20RAC%20Jurisdictions.pdf>

<sup>16</sup> See <http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf>

<sup>17</sup> See Fact Sheets “Details for: CMS Announces New Recovery Audit Contractors To Help Identify Improper Medicare Payments,” October 6, 2008, available at [http://www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp)

There are a couple of key procedural points that apply throughout the appeal process. First, documents, like a notice of an initial or revised determination, are generally presumed to have been received five days after the date of the document. Second, documents, such as appeal letters, are deemed filed when received by the addressee, not when placed in the mail.

The first level of the appeal process is the “redetermination” appeal. A person or entity, such as a hospital, that may be a party to the claim may file request for redetermination with the Medicare contractor when disputing an initial determination of the claim.<sup>18</sup> The request for redetermination must be filed within 120 calendar days from the date a party receives notification of the initial determination.<sup>19</sup> The party must file the request for reconsideration with the contractor indicated on the notice letter.<sup>20</sup> The party may file a request for an extension to file the appeal upon a showing of good cause for missing the deadline to appeal.<sup>21</sup> The Medicare contractor must generally mail or transmit notice of the decision within 60 calendar days of receipt of the request for redetermination.<sup>22</sup>

If an unfavorable redetermination is rendered, the party may file a request for reconsideration with a Qualified Independent Contractor (QIC).<sup>23</sup> This second level appeal must be filed within 180 calendar days from the date the party receives the notice of the redetermination decision.<sup>24</sup> The reconsideration consists of an on-the-record review of the initial determination, considering evidence and findings used to make the initial determination, and any additional evidence submitted by the party or that the QIC obtains on its own.<sup>25</sup>

A party must submit all evidence and allegations related to the dispute with the adverse determination or, absent good cause, the party will be precluded from introducing the evidence at later stages in the appeal process.<sup>26</sup> The federal regulations require QIC members to have sufficient medical, legal and other expertise, including knowledge of the Medicare program.<sup>27</sup> As a general rule, the QIC has 60 calendar days from the date of receipt of the request to render a decision, unless the deadline is extended, such as when the party submits additional evidence through the process.<sup>28</sup>

<sup>18</sup> See 42 C.F.R. § 405.940.

<sup>19</sup> *Id.* at § 405.942.

<sup>20</sup> *Id.* at § 405.944.

<sup>21</sup> *Id.* at § 405.942(b). Examples of good cause include, but is not limited to, a serious illness or death or serious illness in the immediate family, record destruction by fire or other accidental cause, incorrect or incomplete information about the party’s appeal rights, failure to receive the determination decision, or the request was sent in good faith within the time frame but not received until after the time period expired. *Id.* at 405.942(b)(3).

<sup>22</sup> *Id.* at § 405.950. Exceptions to this rule include an extension on the party’s filing date, multiple party appeals, or the submission of additional evidence during the processing period. *Id.* at 405.950(b)(1-3).

<sup>23</sup> *Id.* at § 405.960.

<sup>24</sup> *Id.* at § 405.962.

<sup>25</sup> *Id.* at § 405.960.

<sup>26</sup> *Id.* at § 405.966(a)(2). As with the redetermination level, the party is allowed, however, to submit additional evidence after filing the request for reconsideration so long as the decision is not rendered. This extends the time frames in which the QIC must render a decision. *Id.* at § 405.966(b).

<sup>27</sup> *Id.* at § 405.968(c).

<sup>28</sup> *Id.* at § 405.970.

The third level of appeal is an Administrative Law Judge hearing, which may be heard if the party meets the amount in controversy requirement and is filed within 60 days of receipt of the QIC's reconsideration decision.<sup>29</sup> The ALJ hearing request must be made in writing and include identifying information regarding the beneficiary or entity filing the appeal, the QIC document control number, the dates of service, the reasons for the dispute, and a statement of any additional evidence to be submitted and when it will be submitted.<sup>30</sup> ALJ hearings are held either by telephone, video-conference, or in-person. If a party requests an in-person hearing, the hearing request must state the reasons as to why the hearing should be held in-person.<sup>31</sup> The ALJ may request that CMS or the Medicare contractor participate in the hearing either as a participant or as a party. If they participate as a party, then discovery requests are permissible.<sup>32</sup>

The fourth level of appeal is before the MAC of the Departmental Appeals Board. The MAC appeal must be filed within 60 days of receipt of the ALJ's decision.<sup>33</sup> The written request for MAC review must include an explanation of the sections of the ALJ action that are in dispute. Unless the request is from an unrepresented beneficiary, the MAC will limit its review to the issues identified in the appeal request.<sup>34</sup>

The MAC decision is binding on all parties unless modified by judicial review in a Federal District Court. The appeal for judicial review must be filed within 60 days of receiving the MAC's decision.<sup>35</sup>

## V. LESSONS LEARNED FROM THE DEMONSTRATION PROJECT

The RAC demonstration project provided a wealth of knowledge that may be used to prepare for the permanent program. When the project first started in 2005, providers and suppliers were challenged with unplanned administrative costs in responding to voluminous record requests and pursuing each level of appeal.

In addition, staff personnel were required to take on additional job responsibilities to handle the flood of medical record requests, monitor the recoupment of funds which triggered the right to appeal, draft and submit the necessary documents for appeals, and monitor for timely appeal decisions and refunds of money in the event of favorable appeal decisions.

Providers and suppliers also failed to take into account the difficulty with obtaining assistance from the treating physician or Medical Director in appealing the overpayment determinations. Finally, providers and suppliers were forced to deal with survival issues in the face of rising health care costs and having to return, in some cases, millions of dollars in Medicare money while pursuing the appeals process.

The following is a discussion of some of the problems providers and suppliers faced throughout the demonstration project and the lessons to be learned.

<sup>29</sup> *Id.* at §§ 405.1000; 405.1002; 405.1006.

<sup>30</sup> *Id.* at § 405.1014.

<sup>31</sup> *Id.* at § 405.1020.

<sup>32</sup> *Id.* at §§ 405.1008; 405.1010; 405.1012; 405.1037(a)(1).

<sup>33</sup> *Id.* at §§ 405.1100; 405.1102.

<sup>34</sup> *Id.* at § 405.1112.

<sup>35</sup> *Id.* at §§ 405.1130; 405.1136; 405.1138.

## A. Issues Identified

### 1. Dealing with Record Requests

During the demonstration projects, providers and suppliers received a large volume of requests for medical records for complex review. The request came in the form of a written letter to the hospital identifying the potential for an overpayment and the need to review the medical records for certain claims. It indicated the beneficiary identifying information and dates of service, and the time frame in which to submit the records.

However, medical records staff or persons suddenly tasked with this job were not always informed of the RAC demonstration project and how this differed from routine requests for medical records. Problems arose when the medical records were off-site or unable to be located since failure to produce the medical record resulted in an automatic denial of payment. Additional issues arose because of the large volume of record requests, which often crippled medical record departments and staff and resulted in the failure to maintain a system for submitting the records. As a result, many providers and suppliers failed to keep copies of the packages sent to the RAC or to send a written cover letter and mail the records in a manner which indicated receipt of delivery.

In addition, there were instances in which portions of the medical record were stored electronically and other portions in paper form, resulting in situations where the staff did not submit the complete medical record. Management personnel often did not become aware of this situation until the receipt of RAC letters indicating the overpayment and stating the basis for the denial, which included a failure to produce certain records to support medical necessity for the services billed.

It is critical that systems be developed in advance for handling RAC medical records requests that augment the systems currently in place. It is important that records be complete, well organized, and legible, and that copies of everything sent be retained either in hard copy or electronically.

### 2. Handling RAC Rebuttals and Meeting First Level Appeal Deadlines

Once the demonstration project RAC determined an overpayment existed, the provider or supplier received a letter stating that there was an overpayment, the violation of the applicable Medicare law or rules, and the findings identified. Given complex mailing room or office issues, there were often situations of misplaced letters, which resulted in the lack of a timely evaluation as to whether to appeal the overpayment determination. Very often the overpayment determination letters were placed in someone's mail box and not addressed for quite some time.

There also were instances where the provider or supplier failed to review the letter and identify whether the RAC correctly applied Medicare laws or rules in its overpayment determination (such as in the use of InterQual guidelines to deny inpatient hospital admissions or the three-hour rule to deny inpatient rehabilitation stays). This resulted in providers and suppliers failing to appeal overpayment determinations that were incorrectly issued.

The RAC letter also provided an opportunity for the provider or supplier to file a rebuttal within 15 days to the RAC to discuss the overpayment determination.

However, the rebuttal did not constitute a level of appeal, which often confused providers and suppliers when computing the actual deadline for a request for redetermination. In addition, providers and suppliers often delayed in preparing for the request for reconsideration, expecting to receive a favorable decision from the rebuttal. Given the large number of record requests and denials, the added stress of the rebuttal process often interfered with the ability to submit detailed requests for redetermination to the fiscal intermediary or carrier.

In addition, there were significant issues with computing the deadline for the first level appeal to the fiscal intermediary or carrier. This resulted because of the demonstration's practice to start the 120-day time frame in which to file a request for redetermination from the date the fiscal intermediary or carrier recouped the money not the date of the RAC denial letter. There was a delay (often months) between the date of the RAC overpayment letter and the date the money was actually recouped. This caused providers and suppliers to miss deadlines, as staff responsible for filing the appeals had to rely on information from another department (e.g., the business office) as to when to begin counting the days to appeal.

Often those responsible for calendaring deadlines were different from those in the business office, and even those responsible for filing the appeals, resulting in mistakes. In addition, where the providers and suppliers sent the appeal request prior to the recoupment, the fiscal intermediary or carrier denied the request since they were unaware of any overpayment. These cases were often put aside and staff forgot to, or did not understand that, the claims needed to be re-appealed after the recoupment process, resulting in missed appeal deadlines.

Unfortunately, while the federal regulations provided an opportunity to have late claims reviewed upon a showing of good cause, the fiscal intermediary and carrier typically considered the burden of the RAC process and the provider or supplier's complicated business operations as an insufficient basis for good cause to review the appeal.

It appears that in the permanent program, the RACs will issue the demand letters, which should make it easier for the providers and suppliers to monitor appeal deadlines. It is, of course, very important that demand letters from the RAC be promptly directed to the appropriate individual, and that responsibilities for appeals be clearly delineated.

### **3. Working Through the Medicare Appeals Process**

As could be expected, providers and suppliers suffered tremendously in trying to meet the deadlines and requirements for pursuing appeals through the Medicare Appeals Process. To file an appeal, it must be in writing and meet the regulatory requirements concerning identification of the beneficiary claims, the party appealing, and the basis for disputing the overpayment. The appeal must be received by the entity performing the review by the deadline date. This resulted in major problems since the provider or supplier had to handle ongoing levels of appeals at the same time as it responded to new requests for medical records.

The initial problems began with who was going to draft the appeal letter. Many providers or suppliers consulted legal counsel to help address any applicable legal

arguments. This still required, in many cases, the provider or supplier finding someone to draft the basis for the medical necessity of the services or equipment. Template letters were drafted, which enabled them to keep the basic shell of the appeal letter and just input data for each particular beneficiary claim. The problem occurred when too many people participated in the drafting process, often forgetting to change language in the template letters. This resulted in incidents in which the appeal letter discussed another patient's problems or failed to accurately identify the patient (e.g., female versus male). Moreover, the appeal letter contained extraneous information beyond the basis for the denial of the services or equipment, causing the provider or supplier to lose sight of the initial basis for the appeal.

In addition, given the need to pull resources to address the overwhelming demands of the demonstration project, providers and suppliers often batched their appeals to the fiscal intermediary or QIC in one box without sending a cover letter indicating that there were multiple appeals in the boxes. This became problematic later on when the fiscal intermediary or QIC, who were also overwhelmed with the volume of appeals, began denying receipt of certain appeals. Even if the provider or supplier indicated the mode of delivery on the appeal letter, there was insufficient evidence that the package contained that particular beneficiary appeal unless the staff kept records of the tracking number with each claim, which was often not the case. Providers or suppliers were then forced to appeal to the QIC or Administrative Law Judge for good cause to reverse the dismissal for not filing a timely appeal.

Problems also occurred with mailing appeals and tracking receipt of delivery. The appeal is considered filed as of the date of receipt, not the mailing. Therefore, it is very important for the provider or supplier to document the mode of delivery on the appeal letter and to send the appeal package by a method of delivery to ensure proof of receipt and timely delivery. Often the provider or supplier was not familiar with the mailing process in the entity. For example some providers merely took the packages down to a dock and believed that they would be processed that day. This was not always the case, and providers and suppliers often found out too late that their appeal requests were actually mailed days later. This resulted in appeals arriving beyond the appeal deadline and an ultimate dismissal of the appeal for being filed untimely.

In addition, often the person drafting the letter put the mode of delivery on the letter, but the person responsible for mailing the appeal sent it by another mode of delivery. This inconsistency made it difficult for providers or suppliers when they had to appeal for good cause to review a late appeal, particularly if the responsible person failed to keep sufficient records related to the mailing.

Providers and suppliers also faced difficulties in drafting the appeal letters. They often failed to provide evidence to support the medical necessity for the services rendered. This was particularly problematic when the medical record documentation was difficult to interpret, such as in the case of some electronic charting forms. The appeal letters did not consistently direct the reader as to where to find the information in the medical record. As a result, the reviewer often denied the claims.

There were also problems with monitoring the status of appeals. Providers and suppliers needed to develop a log system to track the record requests, the date of the response letter from the RAC, whether there was an overpayment finding, the date of recoupment by the fiscal intermediary or the carrier, the deadline date for the redetermination request, 60 days from the date of the redetermination to monitor the tentative response deadline, the date for the appeal for reconsideration to the QIC, 60 days from the date of the QIC appeal request for the decision, the deadline date for the ALJ hearing request, the ALJ decision, and recoupment of the funds in the event of a favorable decision. The person maintaining the log needed to calculate in additional days in which to receive the redetermination or reconsideration decisions in the event that the provider or supplier submitted additional information while awaiting the appeal decision. There were often problems with maintaining all this information and consistently updating it as needed.

### **B. Minimizing the Burden of the Permanent RAC Program**

The demonstration project afforded many health care providers and suppliers with a head start in developing an operational process to deal with the demands of the RAC program. In addition, CMS implemented changes to the program that will hopefully ensure a process that is both efficient and appropriate.

In order to minimize the burden of the permanent RAC program, providers and suppliers need to develop compliance processes to address problems prior to the RAC reviews. They should keep track of denied claims and look for patterns. In addition, providers and suppliers should review the demonstration findings to see where improper payments were identified. The permanent RAC findings will be posted on the RAC's Web site, which will allow providers and suppliers to assess their own compliance with these issues. They also

should monitor reports of improper payments located on the CMS Web site.

In order to avoid the issues identified above, providers and suppliers should dedicate sufficient resources and train a team of qualified staff to deal with the RAC demands. There should be a process in place to monitor deadlines for submission of records and appeals. While the RACs will be requesting fewer records than during the demonstration project, the provider and supplier will now be faced with quick turnaround appeal times to avoid recoupment of the funds during the appeal process.

In responding to overpayment determinations, the appeal letters should include clinical arguments that are specific to the particular beneficiary and provide a road map to the sections of the medical record that support medical necessity and that respond to the allegations of the overpayment determination.

Submissions to the RAC or the various levels of appeals should be done in an efficient manner so that the evidence is accessible to the reader. Documents should be paginated and contain document tabs. The provider and supplier should keep a copy of documents and appeals submitted and proof of receipt of delivery.

Finally, the provider or supplier should participate in trade association or town hall meetings with CMS and the RAC representatives to develop relationships and to ensure that the provider or supplier has up-to-date information concerning the RAC process, which may vary from region to region.

## **VI. CONCLUSION**

Health care providers and suppliers need to take the necessary steps to comply with the permanent RAC program. Implementing organizational systems to foster compliance with Medicare coverage requirements and billing for services will enable the provider and supplier to efficiently continue to deliver quality patient care services while living in the world of RACs.