

ADMINISTRATIVE APPEALS OF RAC CLAIMS DENIALS

TELNET 2573 March 25, 2010 1-2 pm EDT

**Presented by
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Agenda

- **Medicare Claims Payment Process**
- **Medicare Standards of Medical Necessity**
- **Types of Medicare Audits**
- **RAC Program**
- **Administrative Appeals Process**

Medicare Claims Payment Process

- **Medicare is required to pay claims within 30 days after being submitted by providers**
 - **Little verification of claims before being paid**
- **After payment, Medicare Contractor can review supporting documentation to ensure items and services were actually provided and Medically necessary.**

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Medical Review

- **This process involves the collection of information, often including medical records, by Medicare contractors to ensure that payment is made only for services that meet all Medicare requirements for**
 - **coverage,**
 - **coding, and**
 - **medical necessity**

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Medical Necessity

Medicare standards for medical necessity are expressed in:

- **Statutes**
- **Regulations**
- **National Coverage Determinations (NCD)**
- **Local Coverage Determinations (LCD)**
- **Inpatient Only List of Procedures**

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Proprietary Screening Tools

- **e.g. InterQual, Milliman & Robertson Care Guidelines**
- **Not endorsed by CMS but Used by Medicare Contractors**
- **Useful tools for Providers to extent they are consistent with Medicare Standards**

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Recovery Audit Contractors

- **Claims of fee-for-service providers subject to RAC review**
- **Claims are reviewed on a post-payment basis**
- **RACS use same Medicare policies as Carriers, FIs and MACS**
 - **NCDs, LCDs and CMS Manuals**
- **RACS are required to employ nurses, therapists, certified coders and a physician CMD**

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Recovery Audit Contractors

- **Demonstration Project began in 2005**
 - **RACs identify “improper payments,” underpayments as well as overpayments**
 - **RACs receive a percentage of amounts they recover**
- **2006 Congress made RAC Program permanent**

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RAC Audits

Two types of RAC audits:

- **Automated**
 - **Based solely on computer analysis of claims data already in government's possession**

- **Complex**
 - **Requires review of patients' medical records**

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RAC Automated Review

Permissible only in situations where clearly the services were not covered or were incorrectly coded or there was a duplicate payment. A denial must be based on

- **a “clear policy” (e.g. statute, regulation, NCD, LCD), or**

- **A medically unbelievable service, or**

- **A failure by provider to timely respond to an ADR**

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RAC Complex Review

Complex medical review is used when copies of the medical record are needed to make a decision about the propriety of the payment.

These reviews require the exercise of clinical judgment by licensed professionals.

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Medical Record Requests Exclusions

Excluded from RAC reviews are claims that have been, or are being, reviewed by any other CMS contractor.

- **CMS will maintain a data base to identify these claims.**

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Medical Record Requests

Claims subject to RAC review:

- **Claims paid after October 1, 2007**
- **Claims no more than three years old**

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Medical Record Requests

Providers have 45 days to provide the records requested by a RAC

- **Provider can ask for extension of time.**

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Medical Record Requests Limits

- **For Inpatient Hospital, IRF, SNF, Hospice**
 - **10% of average monthly Medicare claims (maximum of 200 per 45days)**

- **For Other Part A Billers (e.g. Outpatient Hospital)**
 - **1% of average monthly Medicare services (maximum of 200 per 45 days)**

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Georgia RAC

Connolly Consulting Associates, Inc. has been designated the RAC for Georgia

- **Began in August 2009**

- **Contingency fee is 9%**

- **During the Demonstration Project Connolly was the RAC for Massachusetts and New York**

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Connolly Consulting Demonstration

- **Collected \$266,100,000**
- **Average claim = \$12,157***
- **Per provider per year = \$483,774***

* For inpatient hospital, IRF and SNF

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Connolly Consulting Demonstration

Appeals of Overpayment determinations on Part A Claims:

- **9.9% of claims appealed**
- **51.6% decided favorably to provider**

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Appeals

Provider has 120 days to file appeal after receipt of demand letter.

- **Receipt presumed 5 days after letter date**
- **RAC issues demand letter**
 - **See, Exhibits A & B to “Administrative Appeals of Medicare Reimbursement Determinations”**

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Appeals

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- **RAC issues demand letter**

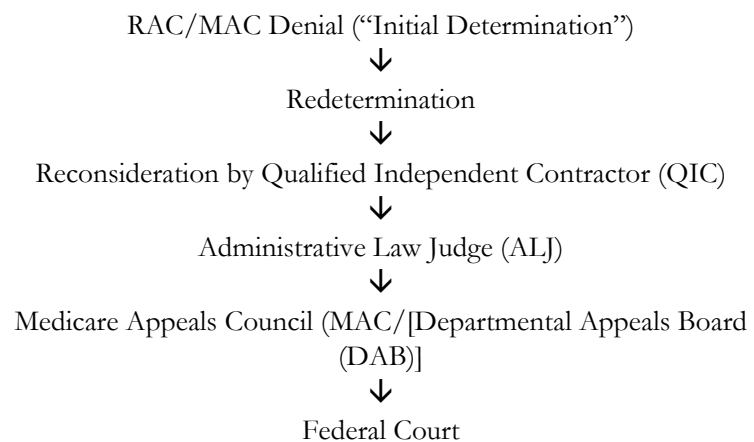
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Appeals

- **RAC letter offers provider 15 days to initiate “Rebuttal” (In some CMS documents termed a “Discussion”)**
- **Discussion period does not toll appeal period**

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Appeals Process



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Stay of Recoupment

- **Filing a timely appeal stays recoupment at the Redetermination and Reconsideration stages only.**
- **120 days to file for Redetermination but recoupment starts on 41st day unless an appeal was in hands of contractor by 30th day.**

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Stay of Recoupment

- **Filing appeal will stop any recoupment that has begun but monies recouped will not be refunded until end of appeal (if Provider wins).**
- **Interest accrues against the provider during appeal (11.25% currently)**

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Interest Against The Government

If the final result of the administrative appeals process is that the government owes the provider money:

- **interest will accrue against the government beginning on the date of the final administrative decision on the matter.**

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Appeal Redetermination

- **First Level of Appeals process**
- **Contractor has 60 days from date of Request for Redetermination to decide appeal**
 - **14 day extension for every submission of additional evidence**
 - **No remedy if Contractor is late – no provision for escalation**

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Appeal Redetermination

Essential elements of Request for Redetermination:

- 1. The Beneficiaries name**
- 2. The Medicare health insurance claim number (HIC)**
- 3. Specific service and/or item for which Redetermination is being requested and dates of service**

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Appeal Redetermination

- 4. The name and signature of the party or representative of the party**
- 5. Explanation why the provider disagrees with the RAC's determination, with any evidence the Provider believes should be considered in the Redetermination.**

There is no AIC requirement

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Appeal Redetermination

- **CMS Form for requesting Redetermination**

Format invites only an abbreviated explanation of grounds for appeal

- **Useful as a checklist of essential elements of Request.**

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Appeal Redetermination

Customized Redetermination Request

- **Expansive discussion of patient's course of care**
- **Emphasizes the aspects of care that support hospital/physician decision-making**
- **Includes references to InterQual and/or Milliman and Roberson Guidelines and rules of law, e.g. treating physician rule.**

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Appeal Redetermination

Persuasive Elements of Request for Redetermination:

- **Description of Hospital's method of organizing its medial records**
 - **An aide to navigation**
- **Creation of narrative description of patient's course of care highlighting elements supportive of Allowability of claim**
- **Statement from treating physician(s)**

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Appeal Redetermination

Persuasive Elements:

- **Organize submitted records in manner that makes your critical documents most easily accessible.**
 - **E.g. organize exhibits with records organized by each day of care.**
- **Use rules of law and screening tools to support reasonableness of decision-making**

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Appeal Redetermination

Ideal Timeline:

- **Day 1 – 10**
 - **Organize team and assign tasks**
 - **Copy, organize and paginate medical record**
 - **Draft care narrative**
 - **Interview clinical staff involved with patient – get affidavits if needed**
 - **Interview treating physician and get statement**

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Appeal Redetermination

Ideal Timeline:

- **Day 10 – 20**
 - **Decide whether to engage RAC with Discussion /rebuttal**
 - **Draft Redetermination Request and coordinate team review**
- **Day 25**
 - **Finalize Redetermination Request and ensure Cahaba receipt before Day 30 to prevent recoupment**

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Appeal Reconsideration By QIC

- **Second Level of Appeal process**
- **180 days from Redetermination to file for Reconsideration**
 - **But recoupment may begin as early as 61st day unless QIC has Request for Reconsideration in hand by that date**

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Appeal Reconsideration By QIC

- **QIC Decision is based on the written record**
- **QIC must issue decision within 60 days of Request**
 - **If QIC fails to do so there is a procedure for Provider to escalate to next level**

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Appeal Reconsideration By QIC

Essential elements of a Request for Reconsideration include the same elements as the Request for Redetermination and in addition:

1.The name of the contractor who made the Redetermination;

2.Any missing documentation identified in the Notice of Redetermination;

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Appeal Reconsideration By QIC

3.Evidence and allegations of fact or law related to the issue in dispute and an explanation why the Provider disagrees with the Initial Determination including the Redetermination.

There is no AIC requirement

Same persuasive considerations as for Redetermination

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Appeal Reconsideration By QIC

Submission of Evidence (Last Opportunity)

Absent good cause, the failure to submit any item of evidence to the QIC before the Notice of Reconsideration is issued precludes consideration of that evidence at any subsequent level of the administrative appeals process.

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Appeal ALJ Hearing

- **No stay of recoupment available**
- **Appeal must be filed within 60 days of Reconsideration Decision.**
- **Same persuasive considerations as for Redetermination**
- **AIC = \$120**
 - **Claims may be aggregated**

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Appeal ALJ Hearing

Essential elements of a Request for ALJ Hearing include the same elements as the Request for Redetermination and in addition:

- 1. The document control number assigned to the QIC appeal;**
- 2. The reasons the Provider disagrees with the QIC decision; and**
- 3. A statement of any additional evidence to be submitted and the date it will be submitted (must have “good cause”)**

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Appeal ALJ Hearing

- Hearing may be by telephone or video conference**
 - For “good cause” in-person hearing may be granted**
 - No additional evidence except testimony**

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Appeal ALJ Hearing

On his/her own initiative or at the request of a party the ALJ may issue subpoenas:

- **If the ALJ decides it is necessary for the full presentation of a case;**
- **For the appearance and testimony of witnesses;**
- **For a party to make available books records, correspondence, papers or other documents for inspection and copying**

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Appeal ALJ Hearing

- **CMS or its contractor may participate if they provide 10 days notice in advance of hearing**
 - **They may file position papers or present testimony to clarify factual or policy issues**
 - **But otherwise may not call or cross examine witnesses**

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Appeal ALJ Hearing

- **Discovery is only available if CMS chooses to participate in hearing**
 - **Production of documents for inspection and copying**
 - **No depositions unless**
 - **Deponent agrees**
 - **ALJ finds it necessary**

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Appeal ALJ Hearing

- **ALJ must issue decision within 90 days**
 - **180 days if case was escalated from QIC**
 - **Appeal may be escalated to MAC if ALJ doesn't issue timely decision**

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Appeal Medicare Appeals Council

- **No stay of recoupment**
- **Review on the record generally**
- **Request must be filed within 60 days of ALJ Decision**

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Appeal Medicare Appeals Council

- **MAC may take case on its own initiative within 60 days of ALJ Decision**
- **CMS may request MAC to consider reviewing ALJ Decision within 60 days**
- **MAC must decide within 90 days.**
 - **Escalation**

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Appeal Medicare Appeals Council

Essential elements of a Request for Medicare Appeals Council Review include the same elements as the Request for Redetermination and:

- 1. The date of the ALJ's final Action;**
- 2. The parts of the ALJ decision with which the provider disagrees should be identified**
 - a. The MAC limits its review to the parts of the decision to which the provider has objected.**

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Appeal Medicare Appeals Council

MAC may issue subpoenas on its own motion or at the request of a party:

- If the MAC decides it is necessary for the full presentation of a case;**
- Requiring books, records, correspondence, papers or other documents to be made available for inspection and copying.**

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Appeal Medicare Appeals Council

**On its own motion or at the request of a party,
the MAC may order Oral Argument:**

- **If the MAC decides that the case raises an important issue of law, policy or fact that cannot readily be decided on the written submissions alone.**

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Judicial Review

- **Case must be filed within 60 days of MAC Decision or of MAC Notice that it can't issue timely decision**
 - **In Judicial District where Provider resides or has PPB**
- **AIC = \$1,220**

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Not *if*, but *how*.®

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