



The RAC Program: What Can Radiology Providers Expect as RACs Begin Auditing?

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EXECUTIVE SUMMARY

- The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program has been made permanent and is expanding nationwide.
- Radiology providers should be ready for increased Medicare auditing activity as the RAC expands.
- Should a provider or supplier be subject to a RAC audit, effective strategies are available that can be successfully employed in the appeals process to challenge denials.

The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) program has been made permanent and is expanding nationwide. Radiology providers all over the country should begin to prepare now for increased Medicare auditing activity. Should a provider be faced with a RAC denial and overpayment demand, such a determination can be appealed through the Medicare appeals process. This article will outline the fundamentals of the RAC program, and will set forth key issues of which all providers should be aware when challenging RAC denials.

RACs: The Beginning

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directed the Department of Health and Human Services (HHS) to initiate a 3 year demonstration program using RACs. The demonstration began in 2005 in the 3 states with the highest Medicare expenditures: California, Florida, and New York. In 2007, the demonstration expanded to include Massachusetts, South Carolina, and Arizona. The purpose of the RAC 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. Over the 3 year demonstration, the RACs identified more than \$1.03 billion in improper payments. The vast majority of this amount, \$992.7 million, constituted alleged overpayments. After factoring in the underpayments returned to providers and suppliers, the claims overturned on appeal as reported to date, the amounts improperly recouped by the RACs and returned to providers upon re-review, and the operating costs of the demonstration program, the RAC program returned \$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.¹

RACs: What's Next?

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 23 states by March 1, 2009, and the remaining states by August 1, 2009 or later.²

On October 6, 2008, 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, CA is the RAC for Region A, including Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and New York;
- CGI Technologies and Solutions, Inc. of Fairfax, VA is the RAC for Region B, including Michigan, Indiana, and Minnesota;
- Connolly Consulting Associates, Inc. of Wilton, CT is the RAC for Region C, including South Carolina, Florida, Colorado, New Mexico, Oklahoma, and Texas; and
- HealthDataInsights, Inc. of Las Vegas, NV is the RAC for Region D, including Montana, Wyoming, North Dakota, South Dakota, Utah, Arizona, Nevada, and California.^{2*}

Before the permanent RACs begin auditing, the RACs will hold “Town Hall” type outreach meetings, at which the RACs and CMS representatives will meet with Medicare providers and suppliers. Medicare providers and suppliers in the first 23 states can expect automated reviews (electronic review of claims data records that do not involve a review of medical records) to begin at any time. Complex reviews (where medical records are requested) were scheduled to begin for coding issues in August or September 2009, and medical necessity reviews are planned to begin in January 2010. CMS recently posted a RAC Review Phase-In Strategy, setting forth these timeframes:³

CMS compensates RACs on a contingency fee basis, based upon the principal amount of collection from (or the amount repaid to) a provider.^{4**} RACs may attempt

*Note that the RAC Expansion Schedule indicates the 4 RAC regions, labeled A, B, C and D. More information is available from the CMS RAC Web site: www.cms.hhs.gov/RAC.

**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.

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to identify improper payments resulting from:

- Incorrect payments;
- Non-covered services (including services that are not reasonable and necessary);
- Incorrectly coded services; and
- Duplicate services.⁴

When performing coverage or coding reviews of medical records, 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 must employ a minimum of one FTE contractor medical director (CMD) (who must be 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, 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 3 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.” In the demonstration program, the “targeted review” resulted in certain categories of providers and certain types of claims being subject to more scrutiny than others.⁴

How Should Radiology Providers Prepare for a RAC Audit?

Radiology providers should begin to prepare now for the RACs and increased Medicare auditing activity. Although providers cannot prevent RAC audits from happening, they can begin to prepare for increased claims scrutiny and RAC activity by dedicating resources to:

- Regularly monitoring guidance documents educating providers regarding the types of claims subject to RAC reviews, including the RAC Web sites (links available from www.cms.hhs.gov/RAC) and other guidance documents identifying areas of Medicare claims scrutiny, such as the Office of Inspector General (OIG) Work Plan.

Note that the RAC demonstration program did not specifically focus on radiology services and that, as of October 2009, the RAC Web sites have not yet identified radiology specific issues for review. However, these sites should be continuously monitored as Medicare approves additional areas for

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RAC review. A review of other guidance documents, such as the 2010 OIG Work Plan, will be helpful to identify areas that may be subject to scrutiny as complex RAC reviews of medical necessity begin. For example, the 2010 OIG Work Plan states that Medicare Part B imaging services will be subject to scrutiny in 2010.⁵

In 2010, RACs are expected to begin complex medical necessity reviews. Although the historical data from the RAC demonstration program does not provide guidance specific to radiology providers, radiology providers must be aware that they can be subject to medical necessity reviews in the permanent RAC program. Even before the commencement of the RAC program, medical necessity reviews of services rendered by radiology providers has always been problematic to radiology providers, given that the services are performed pursuant to the request and order of another provider who has made a determination regarding the medical necessity of the services and has documented the medical necessity for the services ordered in its own records. As radiology providers challenge unfavorable claim determinations regarding the services they perform, they will require access to the ordering physician's records, which may be challenging to obtain. These issues will likely arise during the RAC program, which may prove challenging for the radiology industry.⁵

- Establishing and monitoring internal protocols to better identify and monitor areas that may be subject to review;
- Designating a RAC "point person" responsible to monitor communications from the RAC;

In addition to claim denials resulting from medical necessity and improper documentation and coding, it also is possible for a provider to receive claim denials for federal Stark law violations.

- Responding to record requests within the required timeframes;
- Implementing compliance efforts, including but not limited to (1) educating staff members regarding the potential business impact of RAC audits and the corresponding importance of compliance and appropriate response to RAC records requests and claim determinations; and (2) performing documentation and coding education. Documentation and coding education may entail engaging a qualified healthcare legal professional and coding professional to conduct a formal compliance audit of high risk claims. Notably for radiology providers, in addition to claim denials resulting from medical necessity and improper documentation and coding, it also is possible for a provider to receive claim denials for federal Stark law violations. Therefore, radiology providers should not only ensure that services are appropriately documented and coded, but also ensure that the provider is compliant with the federal Stark law; and
- Tracking claim denials, monitoring and abiding by appeal deadlines, and properly working up appeals to challenge denials in the appeals process. This will likely entail physician involvement.

Types of RAC Reviews

RACs engage in 2 types of claim reviews to identify improper payments: automated review and complex review.

An automated review is a review of claims data without a review of the records supporting the claim. Generally speaking, RACs may conduct automated reviews

only in situations where there exists both (a) a certainty that the service is not covered or is incorrectly coded, and (b) a written Medicare policy, article, or coding guideline applicable to the claim. RACs also may use automated review, even if there is no specific Medicare policy, article, or coding guideline on point, in some "clinically unbelievable" situations or when identifying duplicate claims and/or pricing mistakes.^{6***} According to Commander Marie Casey, Deputy Director of the Division of Recovery Audit Operations at CMS, automated reviews of providers in the first 23 states can be expected to begin at any time.

On the other hand, a "complex review" consists of a review of medical or other records, and is used in situations where there is a high probability (but not a certainty) that a claim includes an overpayment.⁵ In summary, the RAC "complex review" process is as follows: RACs are authorized to (a) visit the provider's location to view and/or copy medical records or (b) request that the provider mail, fax, or otherwise securely transmit the records to obtain medical records necessary to conduct claim reviews. To "securely transmit" medical records means to send those records "in accordance with the CMS business systems security manual, eg, mailed CD, MDCN line, or through a clearinghouse."⁶

During the RAC demonstration program, some providers were overwhelmed by the volume of records requests received from the RACs. In the permanent program,

***A "clinically unbelievable" situation is one where "certainty of noncoverage or incorrectly coding exists but no Medicare policy, Medicare articles, or Medicare sanctioned coding guidelines exist." In these cases, the RAC may ask CMS to approve an automated review. However, unless CMS specifically approves an issue for automated review, the RAC must use a complex review to make such determinations.

If a RAC does not receive requested medical records within 45 days, it is authorized to render an overpayment determination with respect to the underlying claim.

CMS imposed limits on the number of records RACs may request per 45 day period.⁶ For physicians and physician groups, this record request limit is as follows:

- Solo practitioner: 10 medical records per 45 days
- Partnership of 2–5 individuals: 20 medical records per 45 days
- Group of 6–15 individuals: 30 medical records per 45 days
- Large group (16+ individuals): 50 medical records per 45 days.⁶

It is essential that providers timely respond to RACs' requests for medical records. If a RAC does not receive requested medical records within 45 days, it is authorized to render an overpayment determination with respect to the underlying claim.⁷ If the provider appeals this type of denial, "the appeals department may, at CMS direction, send the claim to the RAC for reopening under certain conditions . . ."⁶ However, the carrier or intermediary is not required to send the claim to the RAC for reopening. Thus, providers failing to timely respond to RACs' medical records requests could lose appeal rights with respect to these claims.

Once requested medical records are received, the RAC will conduct its review of the claim. In conducting reviews, RACs are required to comply with National Coverage Decisions (NCDs), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, Local Coverage Decisions (LCDs), and local coverage and coding articles in their respective jurisdictions.⁵ The RACs also are authorized to develop internal guidelines to assist their reviewers to conduct claims reviews consistently with NCDs and LCDs.⁶

Generally speaking, a RAC must complete complex reviews within 60 days from receipt of the requested medical records.⁶ Following its review, the RAC will issue a letter to the provider setting forth the findings for each claim and notifying the provider of its appeal rights.⁶ Alleged overpayments identified by RACs may be appealed through the uniform Medicare appeals process.

Complex reviews regarding coding issues began in September 2009. Complex reviews regarding issues of medical necessity will begin sometime after January 1, 2010.

How to Appeal Claim Denials Made by RACs

RAC denials are subject to the standard Medicare appeals process set forth in 42 C.F.R. Part 405, subpart I. It is important from a business perspective that providers understand the appeals process and appeal claim denials made by RACs. Claim denials made by RACs may be successfully overturned in the Medicare appeals process, resulting in monies returned to the provider.

The 5 stage Medicare appeals process is as follows:

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Stage 1: Redetermination

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

Stage 2: Reconsideration

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

Significantly, 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 be prohibited from introducing evidence in later stages of the appeals process if such evidence was not presented at the reconsideration stage.

Stage 3: Administrative Law Judge (ALJ) Hearing

A provider dissatisfied with a reconsideration decision may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC's decision

and must meet the amount in controversy requirement.

ALJ hearings can be conducted by video-teleconference (VTC), in person, or by telephone. The 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.

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 HHS. 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

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party disagrees. Unless the request is from an unrepresented beneficiary, the MAC will limit its review to the issues raised in the written request for review.

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 MACs decision and meet the amount in controversy requirement.

Strategies for Appeal Claim Denials

Once a provider receives a claim denial made by a RAC, it is important that the provider aggressively pursue appealing the denial through the Medicare appeals process. Experienced healthcare legal counsel

can assist providers with appeals to ensure all available substantive challenges and legal theories are utilized. Experienced counsel will submit an appeal brief/position statement that advocates the provider's position and raises applicable legal challenges, which may include: waiver of liability, provider without fault, challenges to the reopening, and challenges to any statistical extrapolation.

Conclusion

Radiology providers should be ready for increased Medicare auditing activity as the RAC program expands nationwide. Providers should act now to evaluate their compliance with Medicare policy and implement compliance measures as set forth in this article (eg, identifying services

that may be subject to RAC scrutiny and monitoring CMS guidance documents regarding same; designating a RAC point person to respond to RAC communications; responding to RAC record requests within requisite timeframes; implementing compliance efforts including staff education; tracking RAC claim denials and timely appealing). Should a provider or supplier be subject to a RAC audit, effective strategies are available that can be successfully employed in the appeals process to challenge denials. ☸

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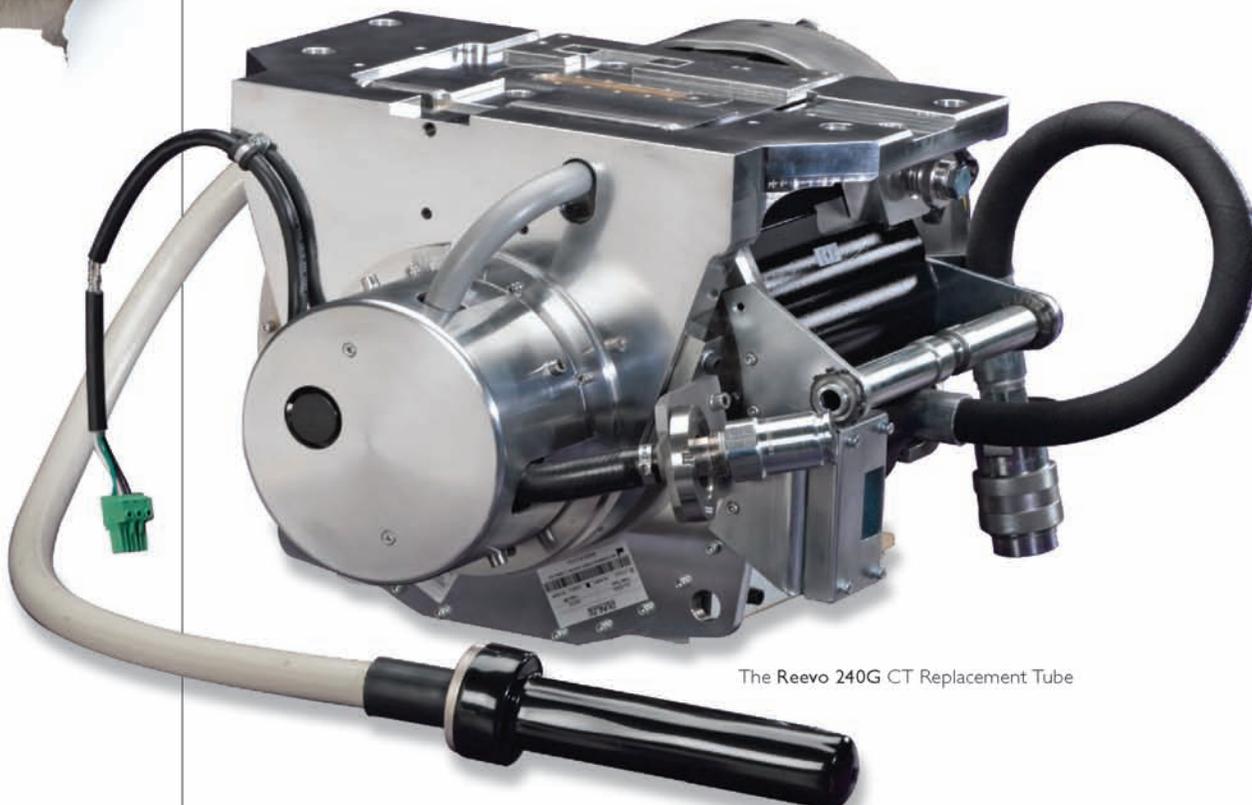
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