

Recovery Audit Contractors and Medicare Audits: Successful Strategies for Defending Audits

By Andrew B. Wachler,
Abby Pendleton &
Jessica L. Gustafson

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. Although hospice providers previously were excluded from RAC auditing activity, RACs are authorized to conduct audits of hospice providers in the nationwide permanent program. Hospice providers should act now to ensure they have adopted and implemented appropriate compliance programs. Hospice providers also should make efforts to understand the Medicare appeals process, and should know that many strategies exist that can be successfully employed in the appeals process to defend Medicare audits.

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 demonstration program expanded to include Massachusetts, South Carolina, and Arizona. The RACs were tasked to identify and correct Medicare overpayments and underpayments, and were compensated on a contingency fee basis. 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 Medicare payments.

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 \$992.7 million in overpayments, and repaid \$37.8 million in underpayments to Medicare providers and suppliers. Based upon information compiled by CMS, the RAC demonstration program cost only 20 cents for each dollar returned to the Medicare Trust Funds.¹

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC program permanent, and requires the expansion of the RAC program nationwide by no later than 2010. CMS is actively moving forward with this expansion. CMS planned to expand to 19 states by summer 2008, four more states by fall 2008, and the remaining states by January

2009 or later.² CMS planned to announce the names of the "permanent RAC" vendors in September 2008. Hospice providers in the first 19 states can expect the commencement of RAC auditing activity soon after the announcement of the "permanent RAC" vendors.

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. As noted above, over the course of the three-year demonstration, the RACs identified and collected \$992.7 million in overpayments and repaid just \$37.8 million in underpayments to Medicare providers and suppliers.³ Thus, approximately 96 percent of the alleged improper payments identified were overpayments, as opposed to underpayments. 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, including DRG miscoding; and
- Duplicate services.⁴

During the course of the demonstration project, Medicare providers and suppliers raised concerns with certain aspects of the RAC program. CMS has made efforts to address these concerns, and has adopted numerous changes to be implemented in the permanent program. Some of these changes include the following:

- Under the RAC demonstration program, RACs were permitted to reopen claims up to four years following the date of initial payment. Amid arguments that this four year look-back period violated the "provider without fault" provisions of the Social Security Act, under the permanent RAC program, RAC reviewers have a maximum three-year look back period. In all states regardless of expansion date, the permanent program will begin with a review of claims paid on or after October 1, 2007. However, as time passes, the RACs will be prohibited from reviewing claims more than three years past the date of initial payment.⁵

¹CMS RAC Demonstration Evaluation Report, June 2008, at p. 2 and p. 15, available at <http://www.cms.hhs.gov/RAC> (last accessed July 14, 2008).

²CMS RAC Demonstration Evaluation Report, June 2008, at Appendix Q. See also *Permanent RAC Expansion Schedule*, available at <http://www.cms.hhs.gov/RAC> (last accessed July 14, 2008).

³CMS RAC Demonstration Evaluation Report, June 2008, at p. 2 and p. 15, available at <http://www.cms.hhs.gov/RAC> (last accessed July 15, 2008).

⁴RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage (last accessed June 4, 2008).

⁵RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage (last accessed July 15, 2008); see also RAC Statement of Work for the RAC demonstration, available at <https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&ctab=core&cview=1> (last accessed July 15, 2008).

- Under the RAC demonstration program, the RACs were not required to employ a physician medical director or coding experts. However, under the permanent program, 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.⁶
- As noted above, CMS compensates RACs on a contingency fee basis, based upon the principal amount of collection or the amount paid back to a provider. Under the demonstration program, the RACs were entitled to keep their contingency fees if a denial was upheld at the first stage of appeal, regardless of whether a provider

prevailed at a later stage of the appeals process. This fee arrangement provided incentive to the RACs to aggressively review and deny claims, including claims alleged to not be "medically necessary," an area containing much subjectivity, and a category of denial often highly disputed by the provider. In fact, 40 percent of the alleged overpayments identified during the demonstration program were denied for reasons of medical necessity. For their efforts, the RACs earned \$187.2 million in contingency payments over the course of the demonstration, or approximately 14.4 percent of all alleged improper payments identified. In a significant change from the demonstration program, under the permanent RAC program, if a provider files an appeal disputing an overpayment determination and 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.⁷

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, they can implement appropriate compliance programs, and make efforts to understand available audit defenses.

Compliance

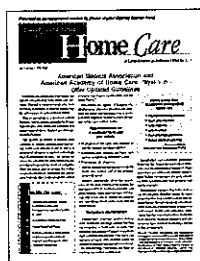
Hospice providers can begin to prepare by dedicating resources to:

- Internally monitoring protocols to better identify and monitor areas that may be subject to review;
- Responding to record requests within the required timeframes;
- Adopting and implementing compliance protocols, including but not limited to providing compliance education regarding common hospice issues such as documentation and coding, and issues involving hospice election statements, certifications, and level of care. Hospice providers should adopt and implement monitoring protocols for patients with certain diagnoses prone to longer hospice stays (e.g. patients with Alzheimer's disease, Parkinson's disease, chronic obstructive pulmonary disease (COPD), heart disease, etc.); and

Referrals, referrals, referrals ... for Home Care

NEW Customized Clinician Educational Newsletter

- Educates physicians
- Builds clinical relationships
- Encourages more referrals



Call us today.
877-513-0099

or email:
info@QoLpublishing.com



www.QoLpublishing.com

⁶RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage (last accessed July 15, 2008); see also RAC Statement of Work for the RAC demonstration available at https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&ctab=core&_cview=1 (last accessed July 15, 2008)

⁷ CMS RAC Demonstration Evaluation Report, June 2008, at p. 2 and p. 15, available at <http://www.cms.hhs.gov/RAC> (last accessed July 15, 2008). See also RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage (last accessed July 15, 2008)

- Properly working up appeals to challenge denials in the appeals process. With regard to medical necessity and similar denials, this will entail physician involvement.

Medicare Audits: The Medicare Appeals Process

If a Medicare provider or supplier receives a claim denial or a finding of overpayment made as a result of a RAC review, the denial will be subject to the uniform Medicare Part A and Part B appeals process. The regulations governing this process are contained at 42 C.F.R. § 405.900 et seq.

Redetermination

The first level in the 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.

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 also is no amount in controversy requirement for this stage of appeal.

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 that which the QIC obtains on its own.

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.

Administrative Law Judge Hearing

The third level of appeal is the 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 reconsideration decision, and must meet an 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.

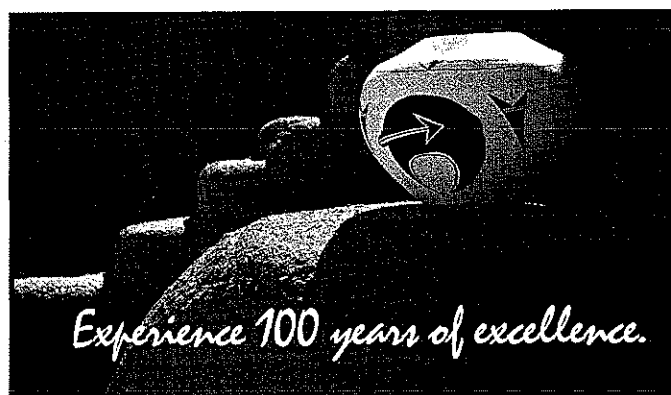
Medicare Appeals Council Review

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 unrepresented 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.

Federal District Court

The final step in the appeals process is judicial review in federal district court. A request for review in district court



Presbyterian Healthcare Services is one of the nation's top 10 integrated healthcare networks and New Mexico's only private, non-profit healthcare system. As we celebrate 100 years of healing, we invite you to join us in enhancing the health of the communities we serve.

Presbyterian's Home Healthcare division is a leading agency in the provision of Home Care, Hospice, Palliative Medicine, TeleMedicine and Case Management services in the Albuquerque metro area. As a Medicare certified and JCAHO accredited agency, PHH provides services to more than 1,500 patients each month. Consider growing your career with a market leader.

We offer an excellent compensation and benefits package as well as the rewards that come from living out our 100-year tradition of quality, compassionate caring. PHS is committed to ensuring a drug-free workplace. EOE.

To learn more about career opportunities at our six New Mexico locations, visit www.phs.org or call 800-708-1151.

 **PRESBYTERIAN**
THE FIRST 100 YEARS

Albuquerque | Clovis | Española | Ruidoso | Socorro | Tucumcari

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.

Strategies for Defending Medicare Audits

Medicare providers subject to RAC or other Medicare audits should understand that various 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.

Advocating the Merits

When advocating the merits of a claim, health care legal counsel assisting hospice 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 color-coded charts or graphs depicting the claims at issue that are user-friendly for the decision maker.

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.

1. 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.

2. 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.⁸ 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 applies to determinations that a service was not medically necessary.

3. 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.⁹

As a general rule, a provider will be considered without fault if it 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.¹⁰ "Fault," for purposes of the provider without fault provision, is defined as follows:

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

⁸42 U.S.C. § 1395pp. See also *Medicare Claims Processing Manual* (CMS-Pub. 100-04), Chapter 30, § 20.

⁹42 U.S.C. § 1395gg.

¹⁰*Medicare Financial Management Manual* (CMS Pub. 100-06), Chapter 3, § 70.3.

- With respect to the overpaid individual only, acceptance of a payment, of which he knew or could have been expected to know, was incorrect.¹¹

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.¹²

4. 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:

- Within 1 year from the date of the initial determination for any reason;

- Within 4 years of the date of the initial determination for good cause as defined in § 405.986;
- At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902; and
- 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:

- There is new and material evidence that—
 - 1 Was not available or known at the time of the determination or decision; and
 2. May result in a different conclusion; or
- 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 decision¹³

¹¹20 C.F.R. § 404.507.

¹² Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3 §§ 80 and 90.

¹³See 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

Hopkins
Since 1945
Medical Products

*Exclusively for Home Healthcare
Quality Products for Quality Care*

Call for a complimentary catalog • 1-800-835-1995 • www.hmponline.com

Hopkins® Rolling Med Bag
 Nursing Bags
 Blood Sample/Needle Disposal System
 Clean/Dirty Side Tote
 Logo Imprinting
 HIPAA Solutions
 CPR Masks
 MRSA Kits Infection Control
 Isolation/MRSA Latex Free
 Clean Up Kits
 Baby Scales and Cases
 Finger Oximeter
 Scales/Cases 440lbs. Capacity
 NEW Pain Management Peer Reviewed Books

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."¹⁴

Notably, although providers in the RAC demonstration program initially experienced success challenging reopenings under these regulations, providers should be aware that at least one Medicare Appeals Council decision has found that CMS lacks jurisdiction to consider challenges to reopenings under the Medicare appeals process.¹⁵

5. 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, 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. Many providers have found it useful to retain the services of a qualified statistician to assist in preparing challenges to statistical extrapolations. For example, in one recent case challenged by this law 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 \$15 million. This firm, utilizing the services of a qualified statistician expert witness, 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 —

- There is a sustained or high level of payment error; or
- 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. CMS and its contractors must follow these guidelines in conducting statistical extrapolations.¹⁶ If it fails to do so, a Medicare provider may have success challenging the validity of the extrapolation.

Conclusion

Hospice providers should be ready for increased Medicare auditing activity as the RAC program expands nationwide. Hospice providers should make efforts now to evaluate their compliance with Medicare policies. 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.



About the Author: Andrew B. Wachler is the principal of Wachler & Associates, P.C. Royal Oak, MI. He is a member of the American Bar Association Health Law Section through which he served on the HIPAA Task Force, the Programs Committee, and the editorial board of *The Health Lawyer* publication. He is also a member of the American Health Lawyers Association. Mr. Wachler has focused his practice on health care law for over 25 years and specializes in all aspects of health care law. He is frequently asked to speak on health care issues, both locally and nationwide.



Abby Pendleton is a partner with Wachler & Associates, P.C. concentrating her practice on health care compliance programs, anesthesia billing and related matters, HIPAA readiness and compliance, medical staff issues, fraud and abuse, third-party payer reimbursement and billing issues, and Medicare, Medicaid, Blue Cross/Blue Shield, and other third party payor audits. She frequently speaks on compliance issues and has co-authored numerous articles on these topics.



Jessica L. Gustafson is an associate with Wachler & Associates, P.C. Ms. Gustafson graduated from Wayne State University Law School in 2005. While in law school, Ms. Gustafson served as a member of the Wayne Law Review Editorial Board as a Senior Articles Editor. She also served as a judicial intern to the Honorable Robert H. Cleland, United States District Court, Eastern District of Michigan.

¹⁴Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80 1.

¹⁵See *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*, decided February 29, 2008.

¹⁶RAC Statement of Work, available at http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage (last accessed June 4, 2008).